Chartbook

A Demographic Portrait of South and Southeast Asia

03404

COMMUNITY HEALTH CELL

Call No : WA - 100

Acc No : 03404

Auther : CHART BOOK

Title : A DEMOGRAPHIC PORTRAIT OF SOUTH AND SOUTHEAST ASIA

Date	Name	Date of return	Signature

Community Health Cell
Library and Documentation Unit
BANGALORE

Chartbook

SEAN SPRAGUE/PANOS PICTURES

Contents

Summary ____ 3

I. Introduction ____ 7

II. Fertility Declines ____ 8

III. Family Planning and Fertility ____ 10

IV. Childbearing Preferences ____ 12

V. Contraceptive Knowledge and Unmet Need ____ 14

VI. Contraceptive Use ____ 16

VII. Education ____ 18

VIII. Regional Variations ____ 20

IX. Maternal Health ____ 22

X. Infant Mortality ____ 24

XI. Child Immunization ____ 26

XII. Traditional Fertility and Health Practices ____ 28

XIII. The Future ____ 31

03404

WA-100

This chartbook is one of an occasional series on population and family planning produced by the Population Reference Bureau (PRB). It was written by PRB staff member Sasha Loffredo, with graphics assistance from Donna Clifton. PRB appreciates the comments and insights from the following external reviewers: Mohammad Alauddin, Bangladesh office of Pathfinder International; Lori Ashford and other reviewers at the U.S. Agency for International Development; Nibhon Debavalya, Population Division, United Nations Economic and Social Commission for Asia and the Pacific; Patricia Rowe, Center for International Research, U.S. Bureau of the Census; Tulshi Saha, Demographic and Health Surveys, Macro International.

We welcome comments and questions from our readers. Please direct correspondence to the following address:

International Programs
Population Reference Bureau
1875 Connecticut Avenue, NW, Suite 520
Washington, DC 20009 U.S.A.

Telephone: (202) 483-1100
Fax: (202) 328-3937

April 1994

DESIGN:
Dever Designs

PRINTING:
Graphic Technology, Inc.

COMMUNITY HEALTH C
LIBRARY
AND
DOCUMENTATION
UNIT
BALTIMORE

Summary

Over the past several decades, Asia's demographic situation has evolved dramatically. Fertility has declined by more than 40 percent since 1960, contributing to significantly improved maternal and child health. Most Asian nations have also witnessed declines in their mortality rates even greater than the changes in fertility.

Drawing on various national-level surveys conducted over the past decade as well as other information, this chartbook highlights the current demographic and health status of South and Southeast Asian populations. Overall, the chartbook illuminates several important findings:

- **In general, Southeast Asia has made greater strides in reducing fertility than South Asia.** This success can be associated in large part with the higher prevalence of family planning practice among Southeast Asian couples.

- **Many women who would like to space their pregnancies or to stop childbearing are not yet practicing family planning.** These women represent a pool of potential users of contraception, and their needs should be closely examined so that programs can better serve them.

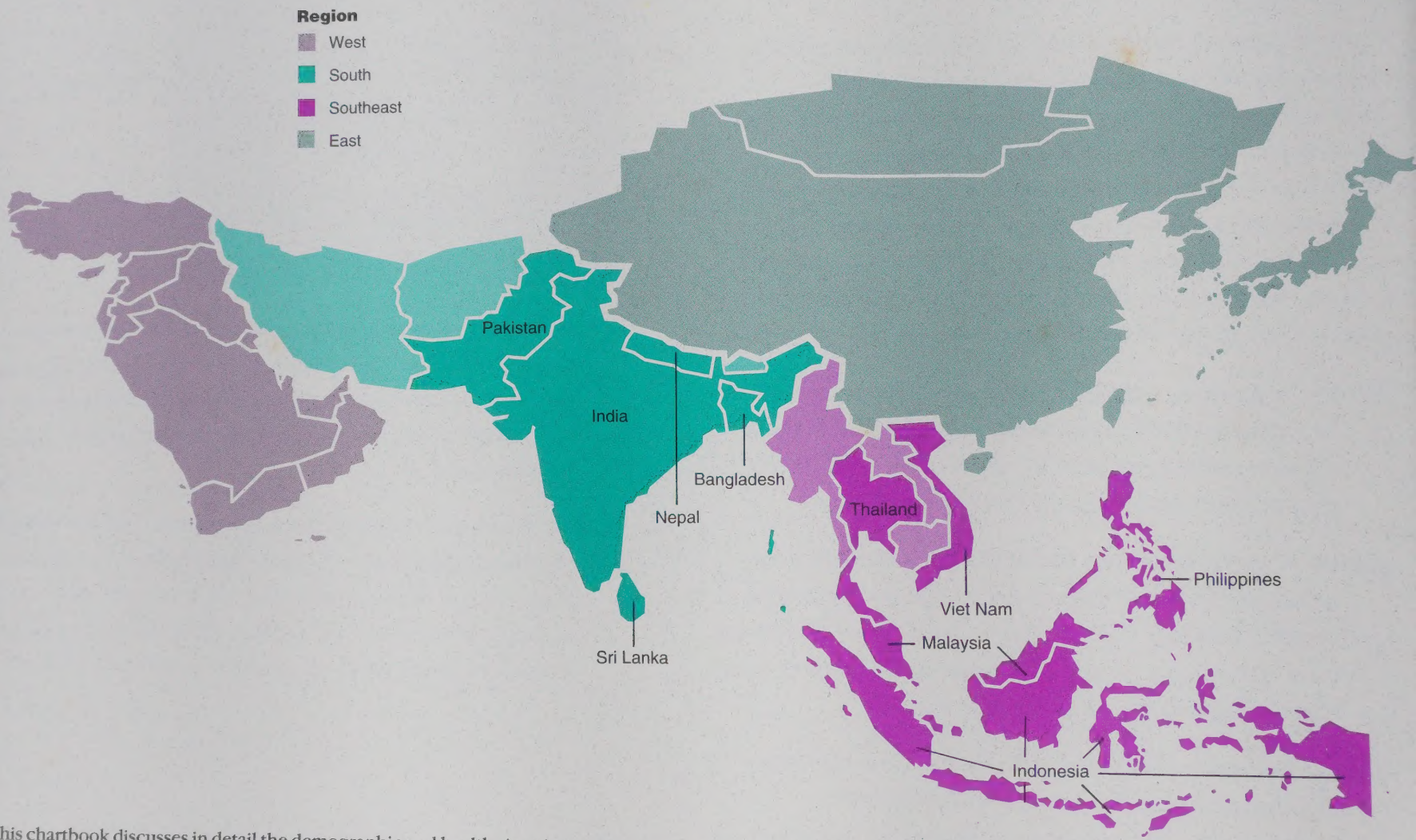
- **Education and place of residence have important demographic impacts.** Leaders can use this kind of information to develop policies and programs that respond more appropriately to women's needs.

SEAN SPRAGUE/PANOS PICTURES

Asia's fertility and mortality rates have declined significantly.

- **Infant and maternal mortality rates are quite high in many Asian nations.** Although there have been substantial improvements in health services over the past 30 years, many mothers and infants are still dying, often from entirely preventable causes.

- **South and Southeast Asian countries continue to face health and population-growth challenges.** Expanding the range of family planning methods available, improving access to maternal health care, and ensuring that all children are immunized are just some of the ways to meet these challenges.



This chartbook discusses in detail the demographic and health situations of ten South and Southeast Asian countries for which national-level surveys have been conducted. Some countries have been excluded from the chartbook due to lack of recent and/or reliable data.

Survey Information

The data for the charts in this chartbook are from the following surveys, unless indicated on the inside back cover:

BANGLADESH

Bangladesh Fertility Survey, 1989
National Institute of Population Research and Training (NIPORT)
Charts 2B, 8B, 12A

Bangladesh Contraceptive Prevalence Survey, 1991
Mitra and Associates
Charts 2B, 4A, 5A, 6A, 7A, 8A

INDIA

Third All India Survey, 1988-1989
Ministry of Health and Family Welfare

INDONESIA

Demographic and Health Survey, 1991
Central Bureau of Statistics, National Family Planning Council and Ministry of Health

MALAYSIA

Malaysian Family Life Survey II, 1988
National Population and Family Development Board
Rand Corporation

NEPAL

Nepal Fertility, Family Planning, and Health Status Survey, 1991
(Preliminary Report)
Ministry of Health

PAKISTAN

Demographic and Health Survey, 1990-1991
National Institute of Population Studies

PHILIPPINES

Contraceptive Prevalence Survey, 1986
Population Institute, College of Social Sciences and Philosophy
University of the Philippines
Charts 6B, 12C

Philippines National Demographic Survey, 1993
(Preliminary Report)
National Statistics Office
Charts 4C, 5C, 6C, 7C, 8C

SRI LANKA

Demographic and Health Survey, 1987
Department of Census and Statistics
Ministry of Plan

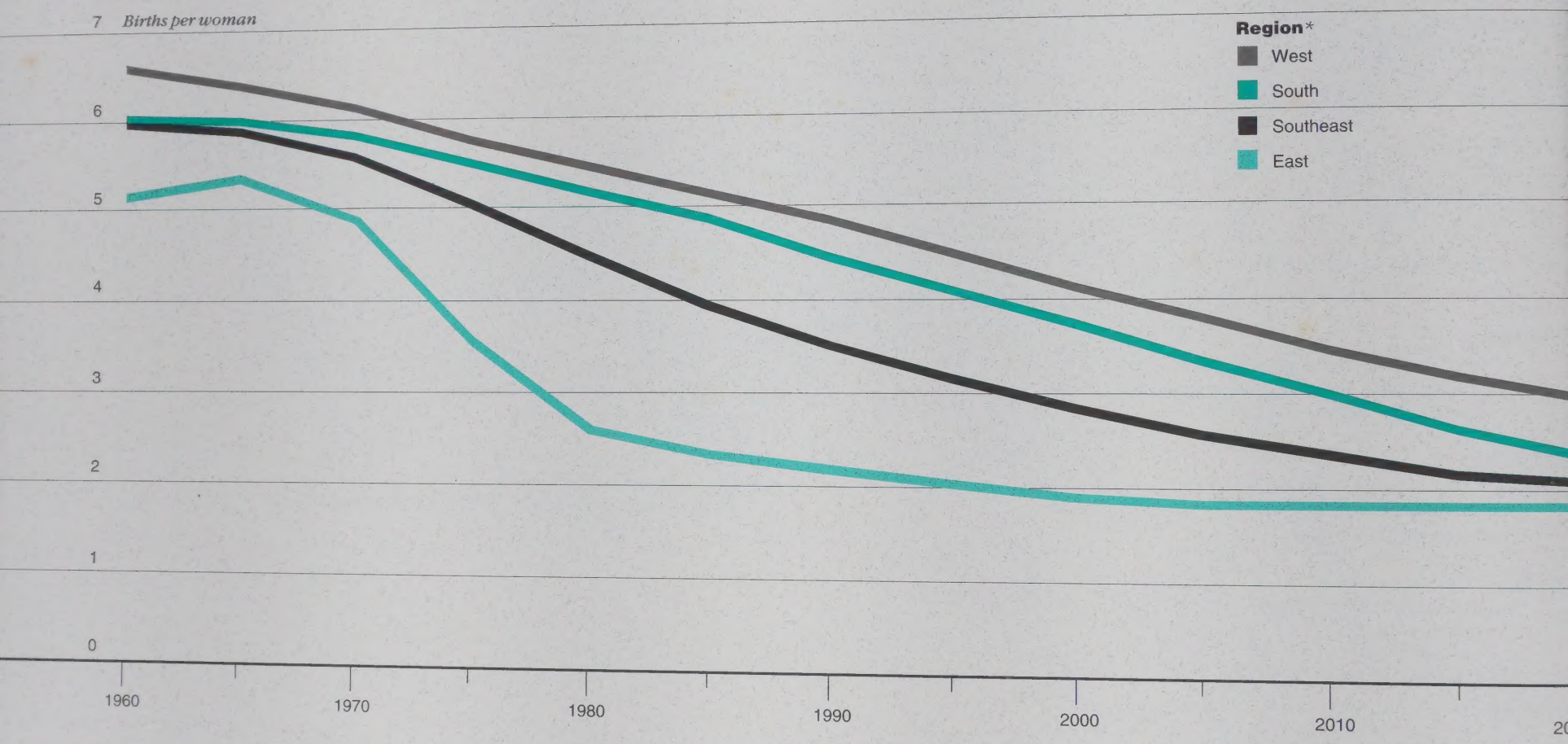
THAILAND

Demographic and Health Survey, 1987
Institute of Population Studies
Chulalongkorn University

VIET NAM

Demographic and Health Survey, 1988
National Committee for Population and Family Planning

Fertility Trends



** The map on page 4 indicates which countries are included in each region.*

I. Introduction

Lower fertility and mortality rates support socioeconomic advances by easing burdens on community services, including health care, housing, and schooling. In turn, improvements in social infrastructure can prompt demographic change, such as the evolution of the small family norm. This synergism leads to a better quality of life for all society.

Throughout Asia, families are benefiting from this relationship through the effects of reduced fertility. However, notable variations in fertility can be found throughout the continent. Chart 1 illustrates past and projected fertility levels in each of the four major regions of Asia. The more developed East Asian countries experienced a more substantial drop in fertility at a faster pace; the other three regions also display evidence of fertility declines over the past several decades that are projected to continue well into the future.

Despite these declines, Asia's total fertility rate* today is still relatively high at an average of 3.2 children per woman; furthermore, when the rate is calculated excluding China's fertility level, a typical Asian woman would bear about 4 children.

This chartbook focuses on the demographic situation in South and Southeast Asia, two very different regions. As shown on Chart 1, fertility levels in South and Southeast Asia were about the same in 1960; however, by 1990, Southeast Asia had experienced more progress in lowering fertility.**

SEAN SPRAGUE/PANOS PICTURES

Women in Asia, excluding China, bear an average of 4 children.

Southeast Asian countries have also made more strides in improving their populations' socioeconomic status on many fronts: enhanced and wide-reaching health services; improved education systems and higher enrollment rates; more modern-sector employment opportunities; and better housing, among others. Thus, lower fertility and socioeconomic advances are mutually reinforcing.

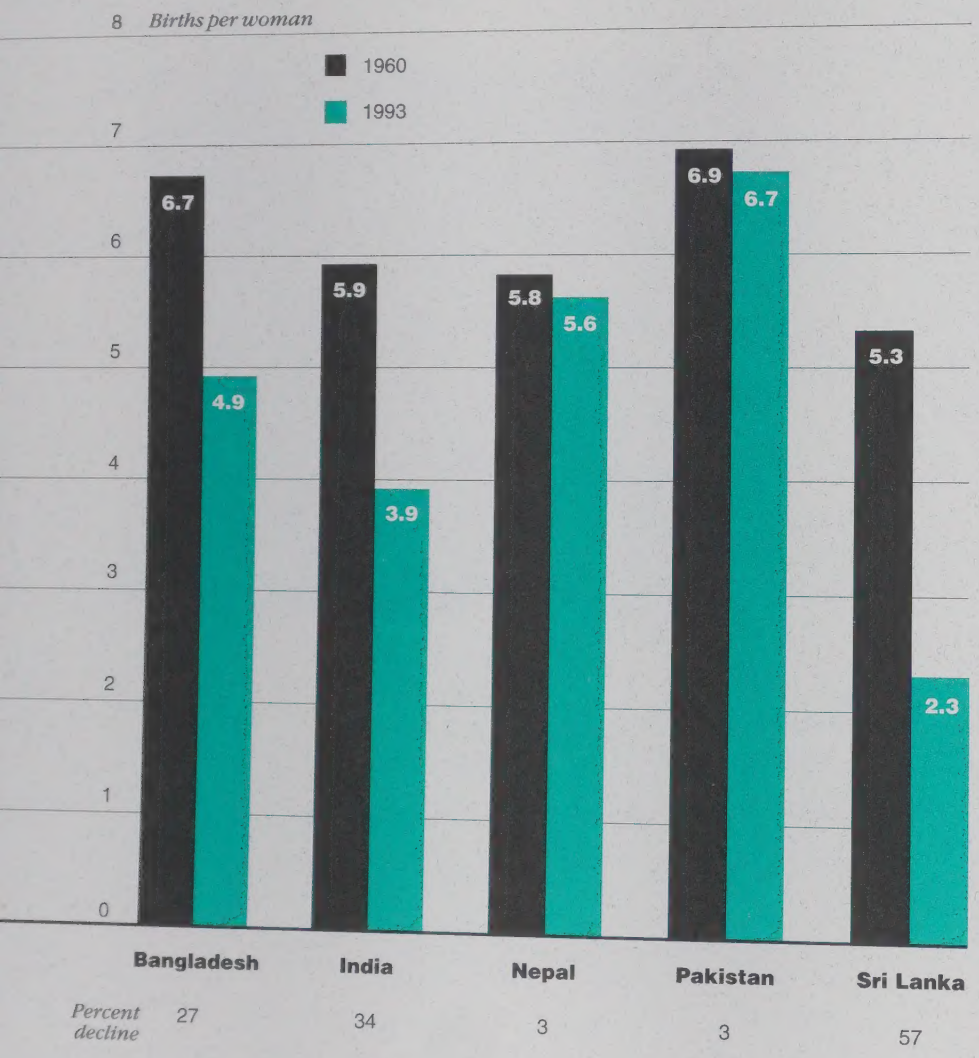
---

* *The total fertility rate is the average number of children a woman would bear if today's age-specific fertility rates remained constant throughout her childbearing years.*

** *The most up-to-date demographic information available can be found in the table on page 32.*

CHART 2A SOUTH ASIA

Decline in Total Fertility Rates



II. Fertility Declines

The extent of fertility decline in South and Southeast Asia varies dramatically from country to country *(see Charts 2A and 2C)*. Although each country began with a high fertility rate in the early 1960s – averaging around six births per woman – by 1993, Southeast Asian nations, overall, had experienced far greater declines than South Asian countries.

- Thailand has seen the most dramatic decrease in its total fertility rate – a decline of 63 percent. Southeast Asian countries have, in general, witnessed declines of 40 percent or more.

- Sri Lanka has experienced a precedent-setting fertility decline in South Asia. In Sri Lanka, where fertility was already relatively low in 1960, women today have, on average, 57 percent fewer births than they would have had 30 years ago.

- Some countries have barely begun the transition from high to low fertility; Nepal and Pakistan have had declines of less than 5 percent during the past three decades.

- Despite its status as one of the very poorest countries in the world, Bangladesh's fertility has declined by 26 percent since 1960. And some parts of India, such as Kerala and Chandigarh, have seen declines in fertility that parallel those found in Southeast Asia.

Trends in Contraceptive Prevalence

Most countries that have undergone striking fertility declines also have had vast increases in the percent of couples practicing family planning. For example, Chart 2B highlights the trend in contraceptive use in Bangladesh. Over the course of two decades, the country's contraceptive prevalence rate increased from 3 to 40 percent, which corresponds to the timing of the fertility decline. Bangladesh's experience proves that even in the absence of socioeconomic improvements, family planning programs can achieve remarkable results.

CHART 2B

Trends in Contraceptive Use
Bangladesh

CHART 2C **SOUTHEAST ASIA**

Decline in Total Fertility Rates

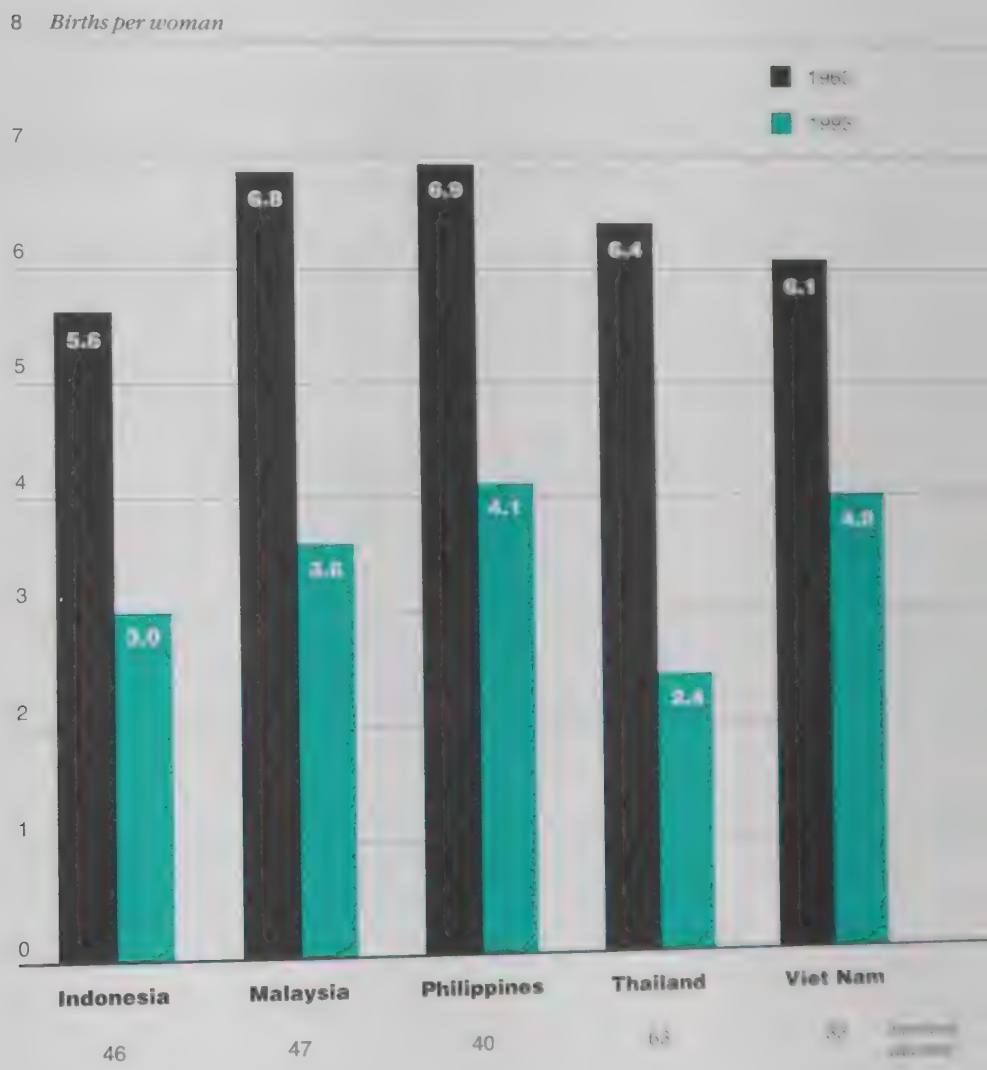
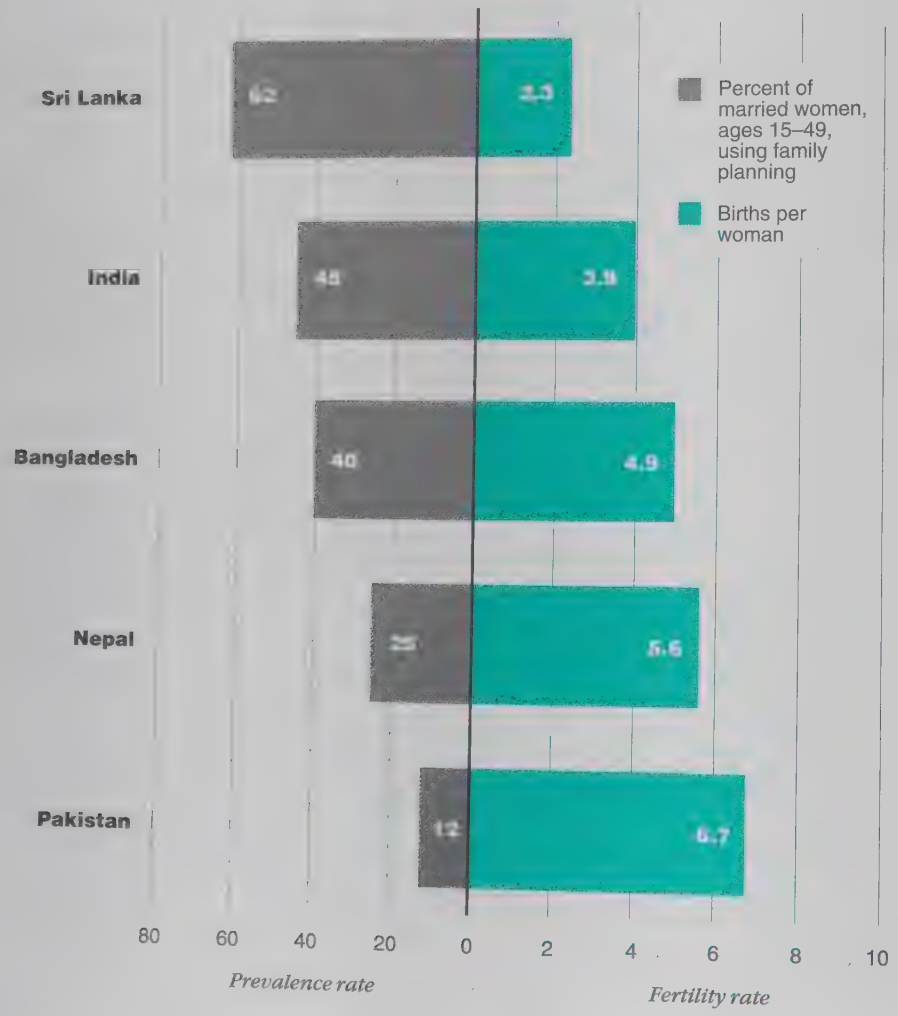


CHART 3A SOUTH ASIA

Contraceptive Prevalence and Total Fertility Rates, 1993



III. Family Planning and Fertility

Widespread practice of family planning is clearly linked with lower rates of fertility. As a rule, family planning use is more prevalent and fertility is lower in Southeast Asia than in South Asia. This fact is partly tied to the higher levels of socioeconomic development found in Southeast Asian countries.

Drawing on the most recent data available, Charts 3A and 3B show the extent to which women currently use contraception in South and Southeast Asian countries and the relationship to fertility.

- In countries where fertility rates are high, as in Pakistan, family planning use is significantly lower than it is in countries like Thailand, where fertility is lower. (In Thailand, fertility is nearly at replacement level,* the point at which the population will eventually stop growing.)

- Indonesian is the only country on these charts that does not follow this general pattern. Among other things, the data suggest that Indonesian women may be using contraceptives more effectively than women in the other Asian countries portrayed here, resulting in lower contraceptive failure rates or, in other words, fewer unintended pregnancies.

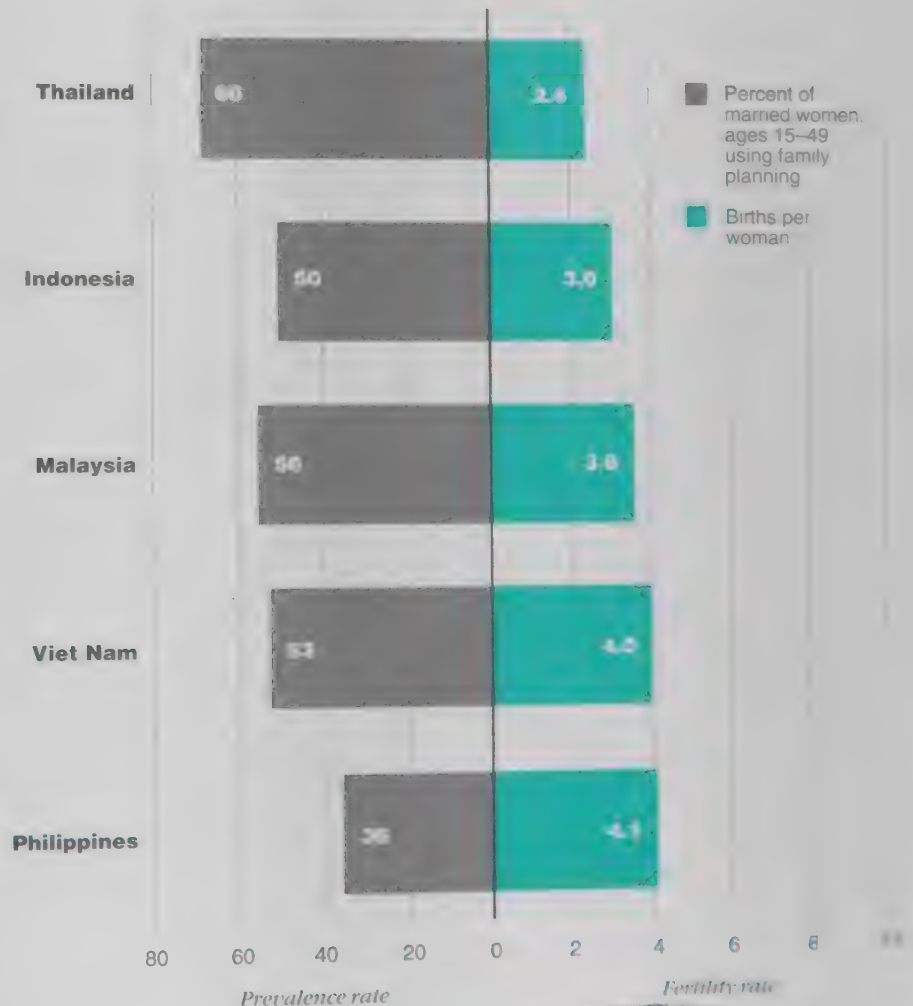
* *Replacement-level fertility is defined as about two children, or one child to "replace" each parent.*

Standing out among its South Asian counterparts is Sri Lanka, where the contraceptive prevalence rate is 62 percent. The country's early attention to ensuring equitable access to various social services including education for girls, extensive health care networks even in rural areas, and wide availability of low-cost contraceptives, accounts for its demographic patterns.

In countries where a significant proportion of couples practice family planning, fertility tends to be lower.

CHART 2.6 SOUTHEAST ASIA

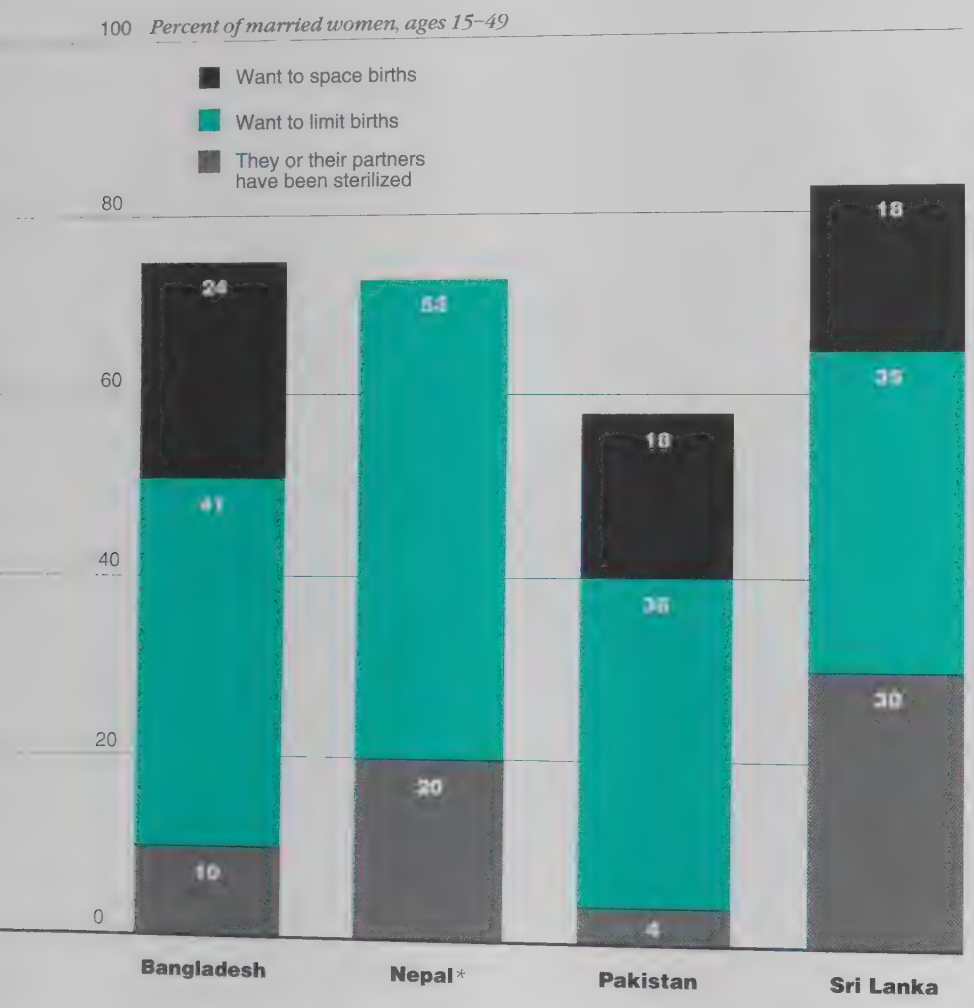
Contraceptive Prevalence and Total Fertility Rates, 1993



COMMUNITY HEALTH LIBRARY AND DOCUMENTATION UNIT BANGALORE

CHART 4A SOUTH ASIA

Women's Stated Reproductive Preferences



*Data on spacing not available

IV. Childbearing Preferences

Numerous country-wide surveys collected information from Asian women on whether they wanted to have more children and from those who did, the desired timing of those births. Charts 4A and 4C show that more than 50 percent of the women who were queried want to stop childbearing or to delay their next births by two or more years.

- The high prevalence of male and female sterilization indicates that many couples have acted on their desire to stop childbearing. As the charts show, in some countries 20 percent or more of the women or their partners have undergone voluntary sterilization.

- Even in countries where data on spacing preferences are unavailable, such as Viet Nam and Nepal, at least half of the women say they do not want to become pregnant. And in some countries, like Indonesia, the Philippines and Bangladesh, more than two-thirds of the women wish to space or limit births.

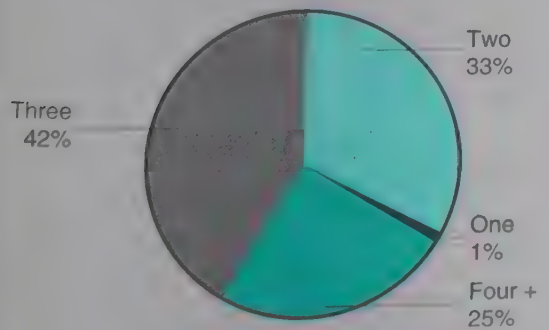
Understanding women's reproductive intentions can assist in the implementation of appropriate family planning programs. For example, many of the women who expressed interest in planning their families are not using contraception *(see Chart 5B)*. Program managers could investigate why this is so and modify their services to address these women's particular needs.

Desired Family Size

A variety of factors can influence a woman's response to survey questions about her childbearing preferences, including her current family size or her vision of the ideal number of children. Chart 4B shows that nearly half of the Indian couples interviewed feel that having three children is most desirable, and another quarter envision four children in the ideal family. These views affect a couple's reproductive decisions and can result in high levels of fertility regardless of whether family planning is accessible.

CHART 4B

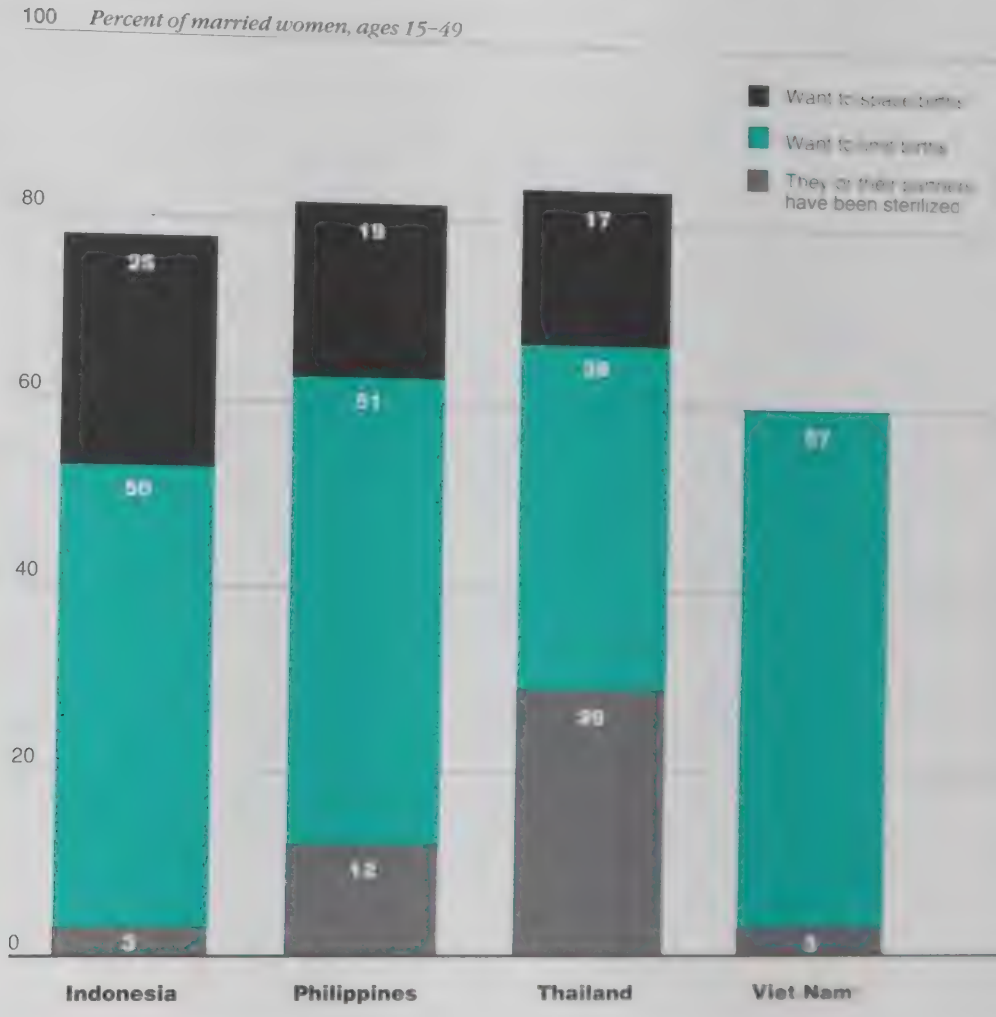
Reported Ideal Family Size*
India, 1988–1989



**Numbers do not add to 100% because of rounding.*

CHART 4C SOUTHEAST ASIA

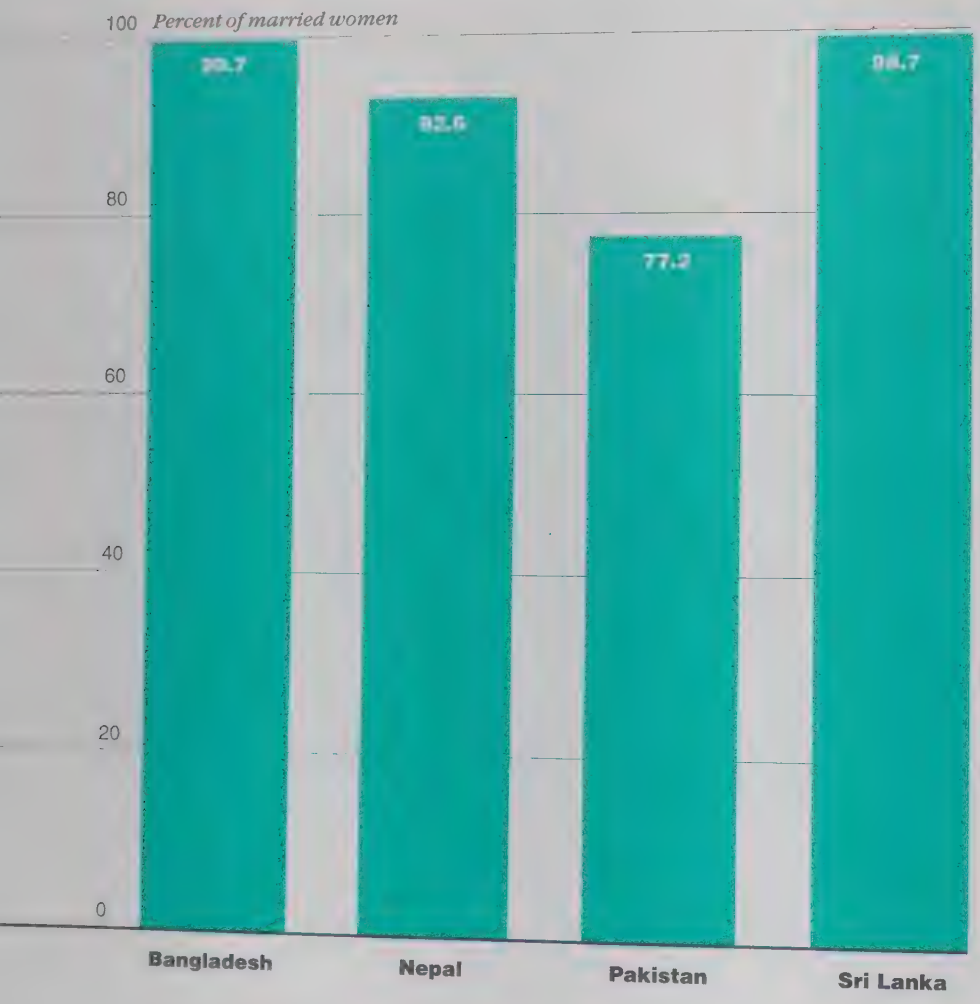
Women's Stated Reproductive Preferences



**Data on spacing not available*

CHART 5A SOUTH ASIA

Knowledge of Family Planning*



Knowledge of at least one modern method

V. Contraceptive Knowledge and Unmet Need

Throughout much of Asia, women are extremely knowledgeable about family planning. In seven of the eight countries listed on Charts 5A and 5C, more than 92 percent of women had heard of at least one modern contraceptive method.

However, even though many Asian women know about contraceptive methods and would like to limit or space their births, some are still not practicing family planning. Demographers say that women who fall in this category exhibit an "unmet need" for family planning. Chart 5B details levels of unmet need for family planning in four countries.

Unmet need exists for a variety of reasons. In some cases, women do not know where to obtain services, or they may not trust the quality of the services they do know about. In other cases, services offering contraceptive information and methods simply do not exist.

In countries where reproductive health knowledge is particularly low, the first step in reaching higher levels of contraceptive use is making women aware of contraception and the benefits of planning their families. In a comparison of Chart 5A and Chart 5B, Pakistan stands out. Even though Pakistani women have expressed the desire to control their fertility, nearly a quarter do not have even a basic understanding of the options that exist.

RON GILLING/PANOS PICTURES

Many women in Asia who are not yet practicing family planning say they would like to either delay the births of their next children or cease childbearing.

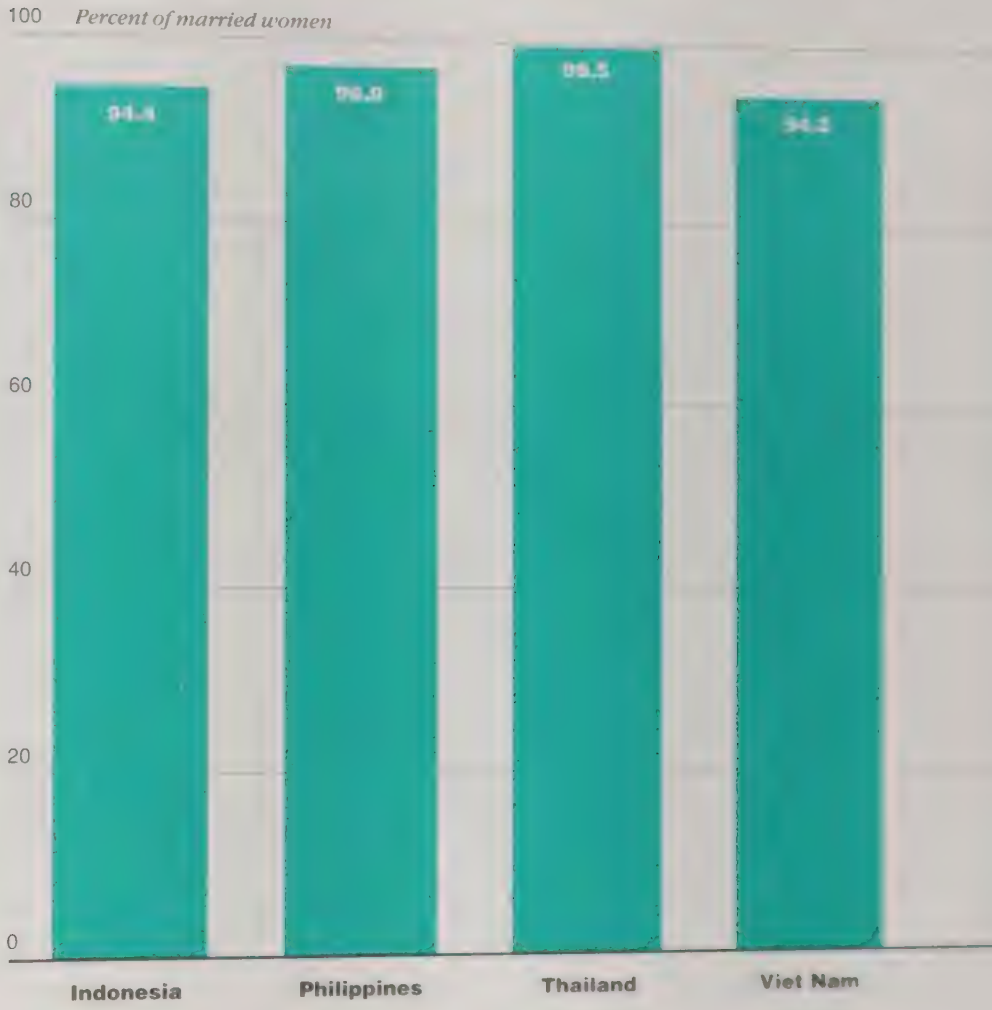
Furthermore, family planning services are not readily accessible in Pakistan. Thus, there are higher levels of unmet need in Pakistan than in some of its Asian neighbors. Once these women become aware that they can plan their families, they need access to safe, high quality family planning services.

CHART 5B

Unmet Need for Family Planning

CHART 5C SOUTHEAST ASIA

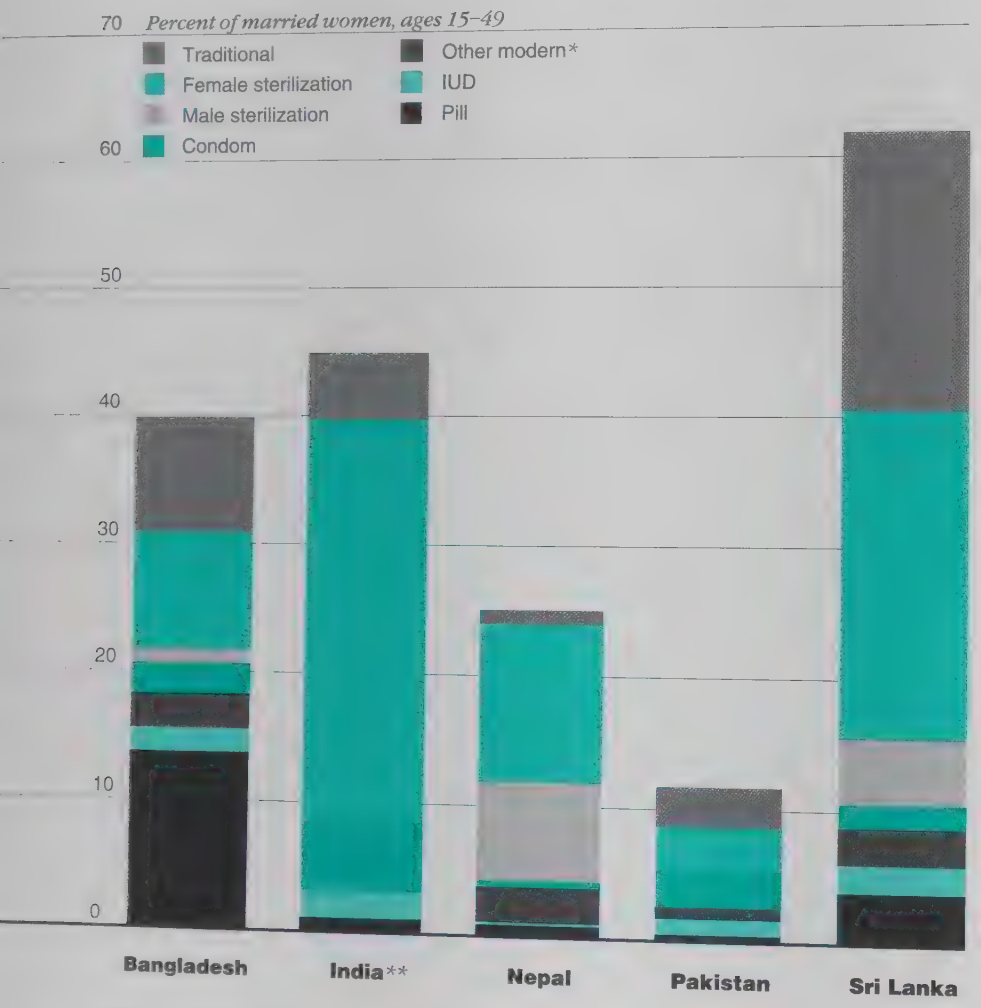
Knowledge of Family Planning[a]



[a]Knowledge of at least one modern method

CHART 6A SOUTH ASIA

Current Use of Family Planning by Method



*Includes implants, injections, and vaginal methods

**Ages 15–44; male and female sterilization combined

VI. Contraceptive Use

The types of family planning methods available are important determinants of whether a woman opts to use contraception. Charts 6A and 6C portray the kinds of contraceptives couples are using in South and Southeast Asia. The "method mix" – or range of family planning methods used by couples – varies from country to country:

- In countries with sophisticated and extensive family planning programs, such as Thailand, Indonesia, and Bangladesh, fewer women rely on traditional means of family planning. Furthermore, in most high prevalence countries, couples use a wide variety of contraceptives.

- In some countries with widespread contraceptive use, however, one or two methods predominate. For example, in India and Sri Lanka, sterilization is the most common modern method, and in Viet Nam, most women rely on the IUD to plan their pregnancies.

- In a handful of countries, male methods of family planning account for a relatively significant proportion of methods used. In Nepal and Sri Lanka, for instance, many couples depend on male sterilization and/or the condom.

Discontinuing Use

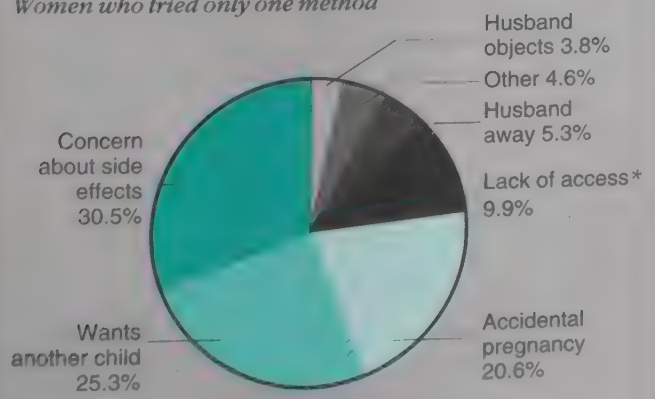
In addition to the women currently practicing family planning, many others used contraception in the past but stopped for one reason or another. Chart 6B highlights the reasons given by Filipino women who have tried only one method. Accidental pregnancy – resulting from incorrect use, choice of an ineffective method, or method failure – and side effects are leading causes of discontinuation among women who were not planning a pregnancy. Unfortunately, these reasons can often deter women from switching to another method.

However, for those women who have tried more than one type of contraceptive, reported accidental pregnancy drops dramatically to less than 1 percent while factors associated with a desire for pregnancy and a husband's temporary absence increase. Since not all contraceptives are appropriate for all women, family planning programs that offer women a variety of methods from which to choose and that make it easy for women to switch methods often achieve higher continuation rates.

CHART 6B

Reasons for Discontinuting Contraceptive Use, Philippines, 1986

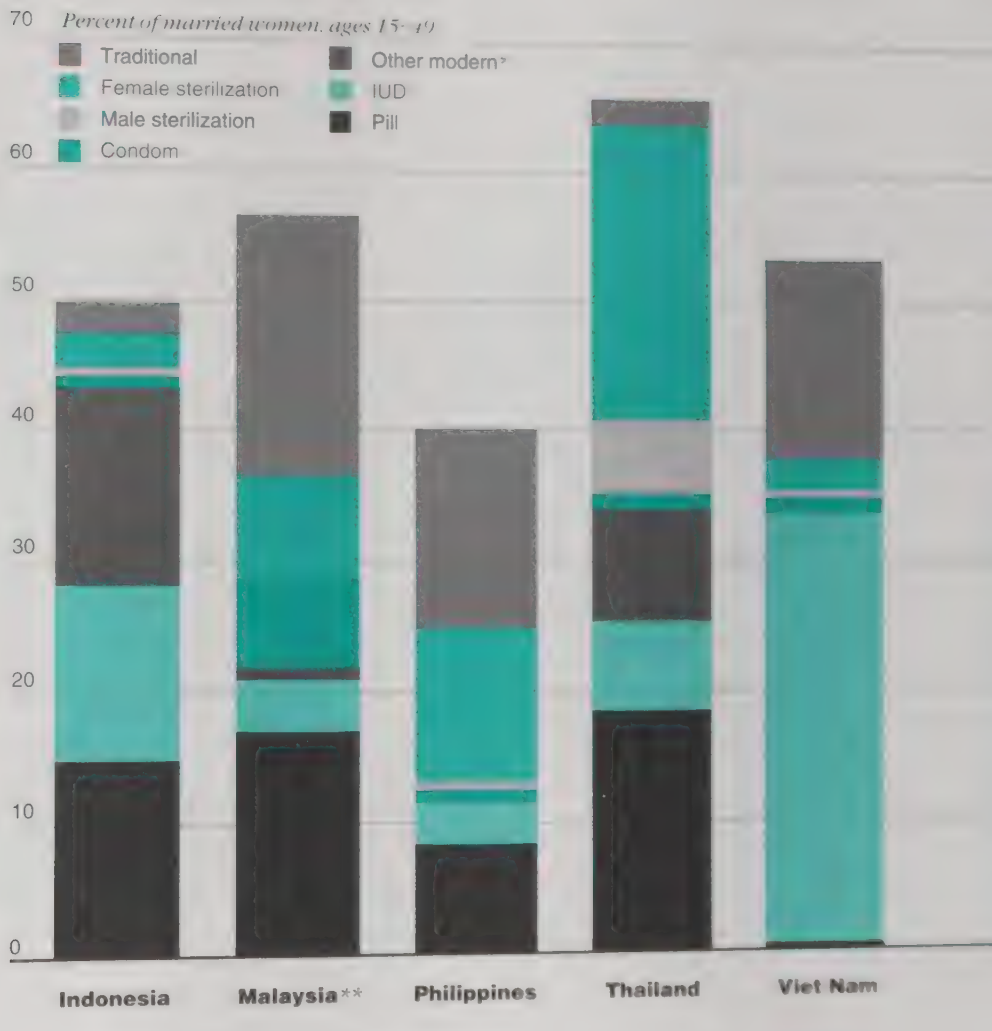
Women who tried only one method



**Includes lack of supplies, inconvenience, and expense*

CHART 6C SOUTHEAST ASIA

Current Use of Family Planning by Method

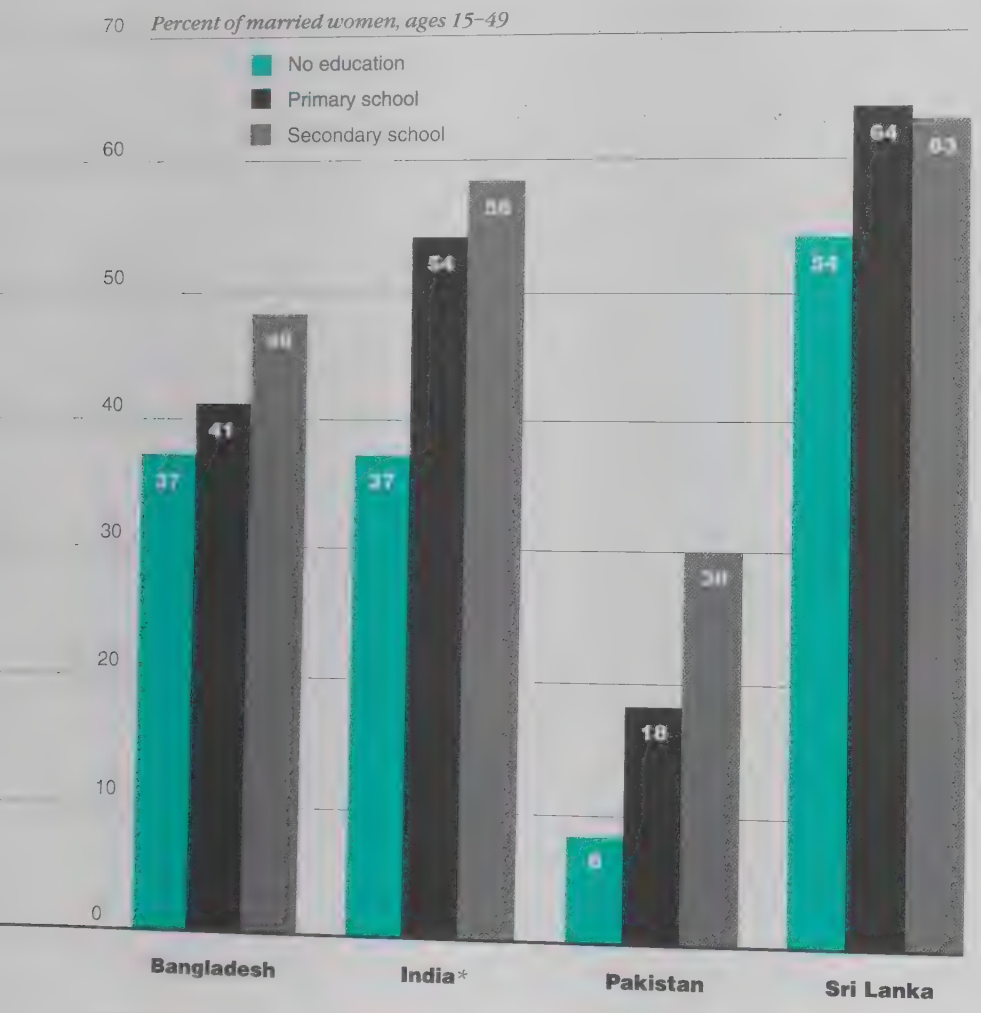


**Includes implants, injections, and vaginal methods*

***Male and female sterilization combined*

CHART 7A SOUTH ASIA

Contraceptive Prevalence by Level of Education



*Ages 15–44

VII. Education

Increasing educational opportunities for girls enhances their status in the home and the community, in part because better educated women have more employment options. Furthermore, schooling for girls often enables them to exercise control over important aspects of their lives. As Charts 7A and 7C illustrate, women with at least some schooling are more likely to plan their families.

- The positive relationship between education and family planning practice is virtually universal throughout the continent: in South and Southeast Asia, a higher proportion of women with at least some education use contraception than women with no education at all.

- Often, where overall contraceptive prevalence is low, the difference in prevalence rates between educated women and uneducated women is far greater. The Philippines and Pakistan are examples of this, where family planning prevalence differences amount to as much as 30 percent.

- On the other hand, in high prevalence countries the effects of education are generally less dramatic. In Thailand and Sri Lanka, there is less than a ten-point difference in prevalence between uneducated women and women with secondary school training.

Women with more education are more likely to plan their pregnancies; thus these women are likely to have fewer children and have them at times that are more opportune for themselves and their families. Chart 7B highlights the relationship between education and fertility in Thailand.

CHART 7B

Total Fertility Rates by Level of Education, Thailand, 1987

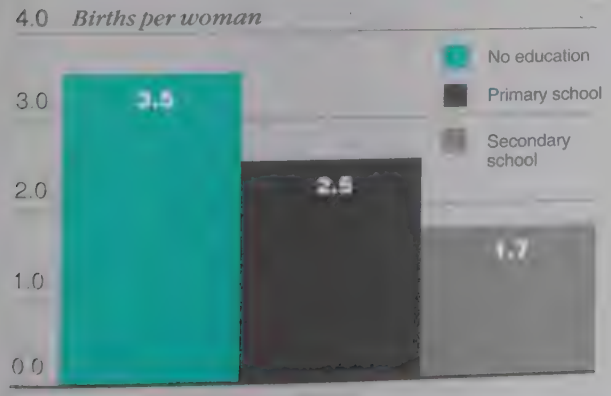
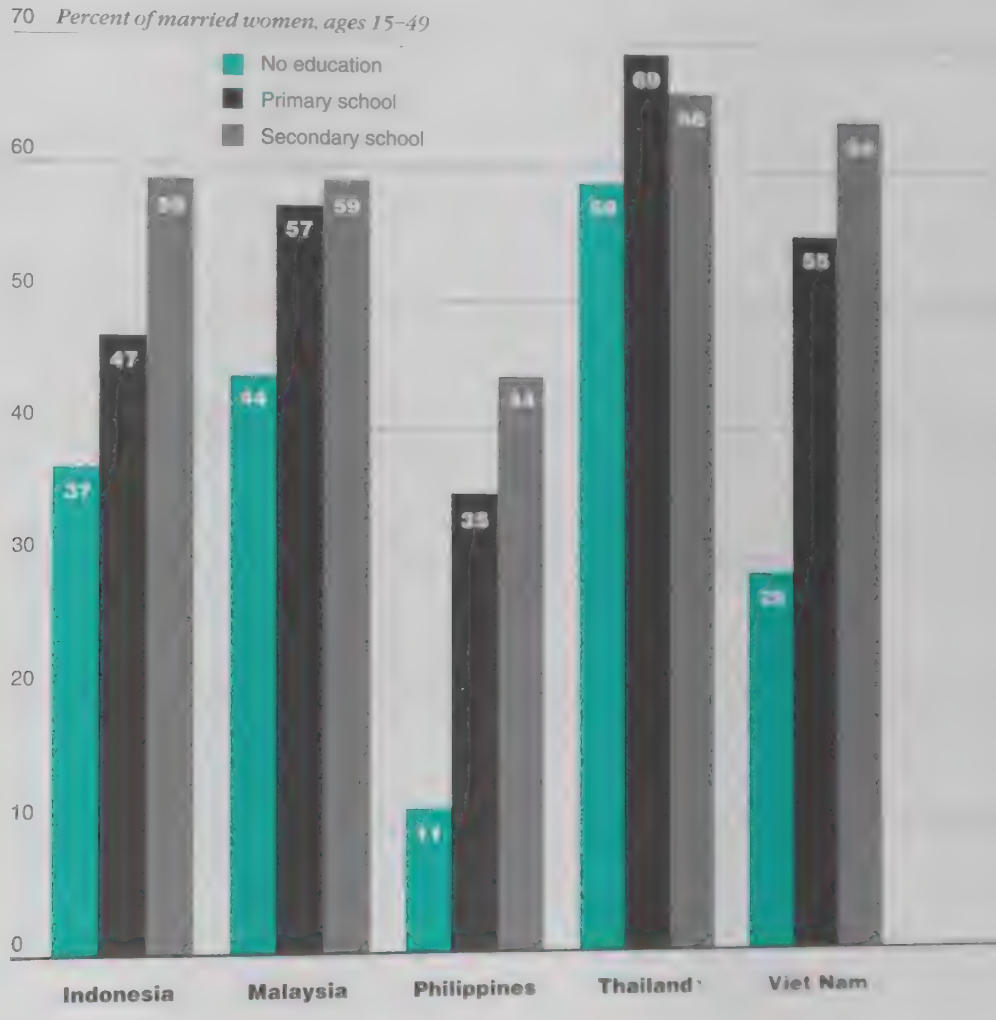


CHART 7C SOUTHEAST ASIA

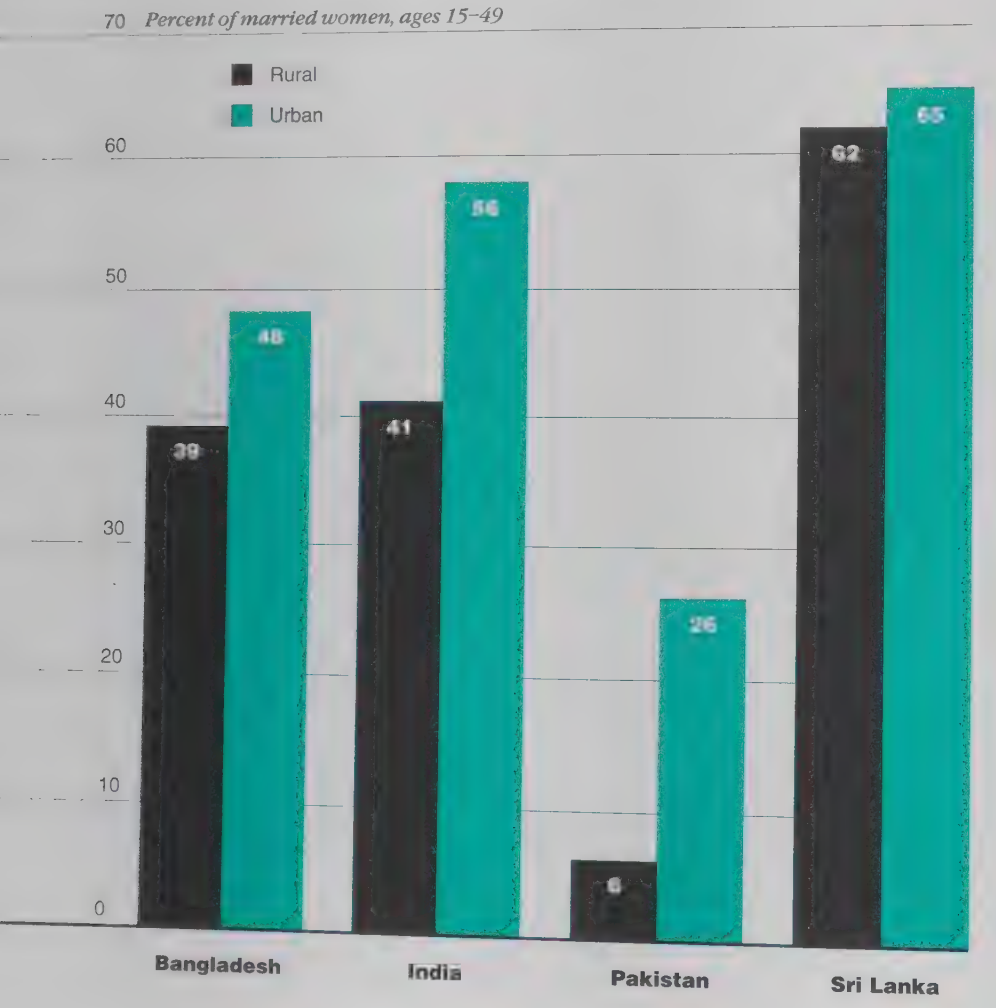
Contraceptive Prevalence by Level of Education



*Ages 15–44

CHART 8A SOUTH ASIA

Contraceptive Prevalence by Area of Residence



VIII. Regional Variations

A higher proportion of women in urban areas of Asia practice family planning than in rural areas; this is typical of most developing countries. Charts 8A and 8C portray these differences in South and Southeast Asia.

- In countries with relatively widespread contraceptive use, urban/rural differentials are minimal. Sri Lanka and Thailand, for example, have extensive family planning programs that reach rural areas, resulting in prevalence rates in rural areas that are higher than most of their neighbors' urban rates.

- Countries with low contraceptive prevalence, such as Pakistan, often have substantial urban and rural differences. Family planning programs in these nations are still in the initial stages of service delivery, which often focus primarily on densely populated areas.

- High urban/rural differentials can also be the result of a program's reliance on methods that require sophisticated service delivery, which is usually more accessible in urban areas. India, where the majority of contraceptive users rely on sterilization, is an example of this.

Disparities in family planning practice also exist within regions of individual countries. Chart 8B reveals the varying levels of contraceptive prevalence and the corresponding fertility rates in the four divisions of Bangladesh. Each of these divisions is predominantly rural,

ranging from 2.5 percent urban in Rajshahi to 12.5 percent urban in Dhaka; thus the demographic variations between these regions can not be attributed just to urban/rural differences. Regional disparities like those depicted on the chart occur for a number of reasons including different levels of access to family planning and health services, religious or cultural differences, and diverse socioeconomic conditions. Information like this can help program planners tailor service-delivery approaches.

CHART 8B

Regional Variations
Bangladesh, 1989

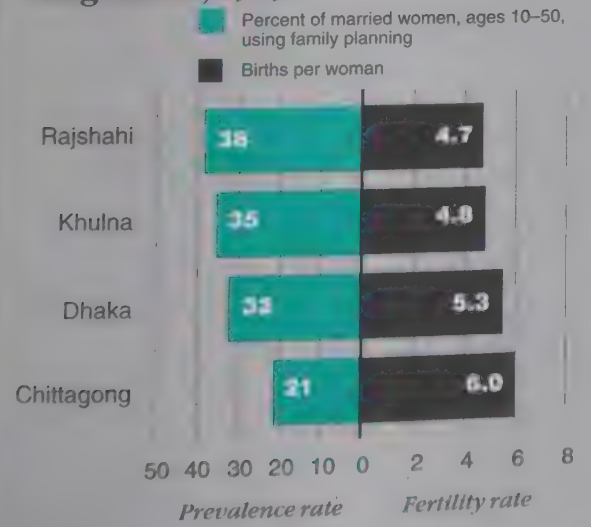
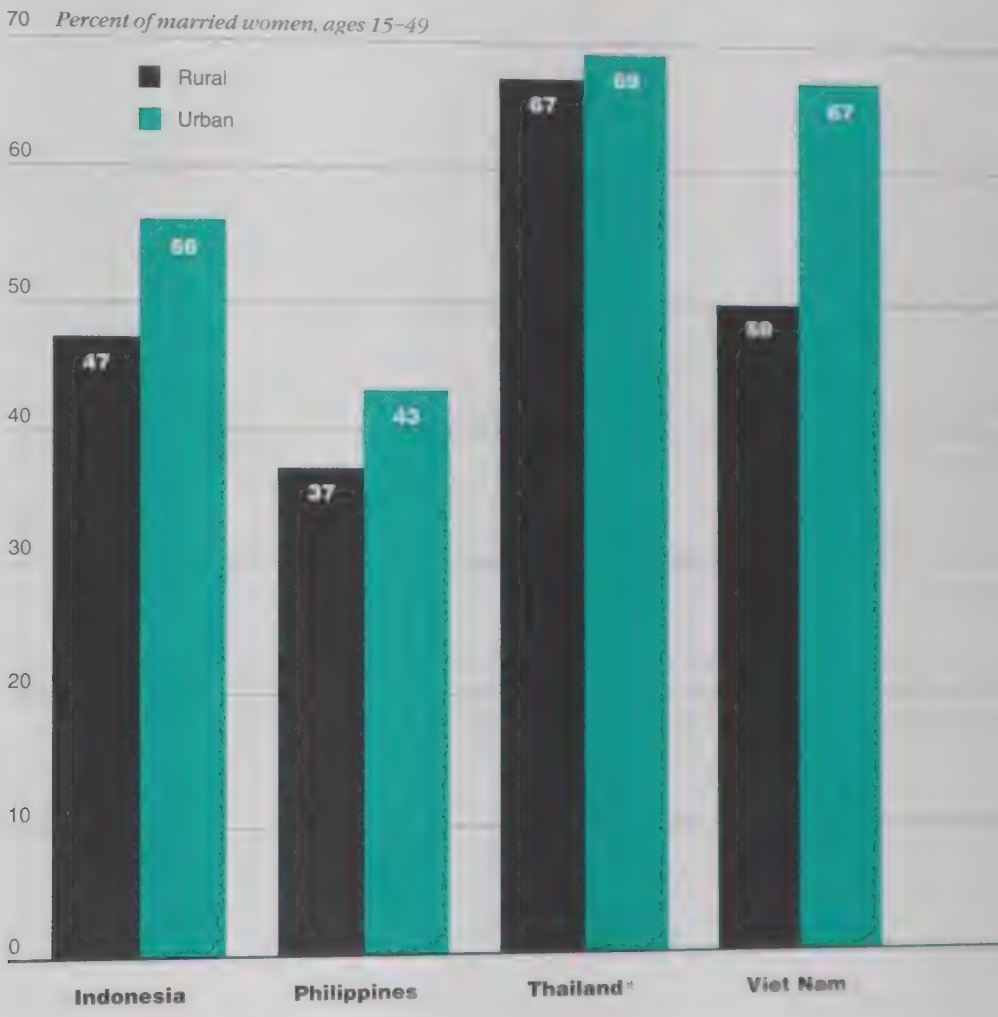


CHART 8C SOUTHEAST ASIA

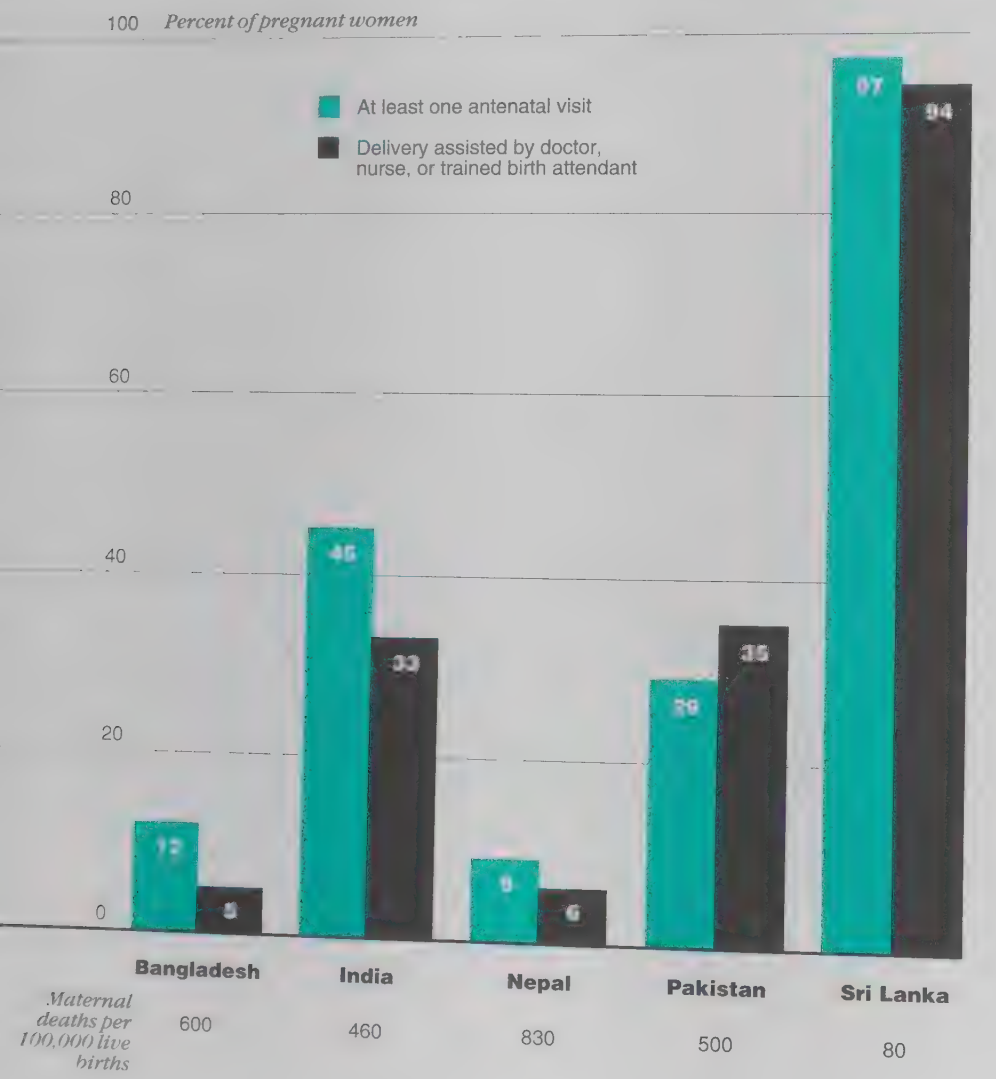
Contraceptive Prevalence by Area of Residence



*Ages 15–44

CHART 9A SOUTH ASIA

Maternal Care



IX. Maternal Health

In the developing world, complications during pregnancy and childbirth – including unsafe abortion – are the leading cause of death among women of reproductive age. During routine antenatal care visits, health workers can identify potential risk factors and take precautionary measures. In addition, trained assistance during delivery can help reduce the risk of illness or death. Charts 9A and 9C show the prevalence of antenatal care and attended deliveries in South and Southeast Asia.

- Overall, a higher proportion of Southeast Asian women receive maternal care. Not only is access to antenatal care and delivery assistance better, but more women in Southeast Asia understand the benefits of maternal care.

- In South Asia, women are more likely to receive antenatal care than be assisted by a trained attendant during childbirth. Often, South Asian women, who have to travel long distances for health services, can plan in advance for an antenatal visit, but not for childbirth.

- Because of the lack of antenatal care and assistance during childbirth, almost half of all maternal deaths worldwide occur to South Asian women *(see Chart 9B)*.

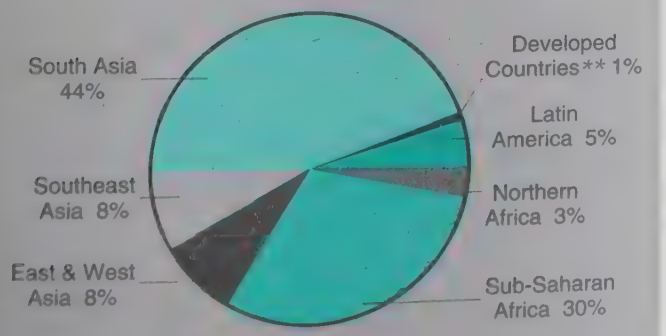
Reducing pregnancy-related complications is the first step to improved maternal health. This can be achieved by informing women about the importance of antenatal care and improving access to it so that more women can obtain such services. The second step is to prevent death when complications arise. Women should have trained assistance during childbirth, and ideally give birth close to a source of emergency care.

Family planning services are an important component of maternal health care. Providing women with access to contraception can lower maternal mortality because family planning helps women who are at higher risk of maternal illness or death avoid pregnancy altogether.

The Demographic and Health Surveys have determined that antenatal care and assisted delivery can also significantly reduce the risk of infant mortality in the first month of life (also called neonatal mortality). Thus, programs that provide maternal care also make a contribution to improved child survival.

CHART 9B

Regional Percentage of Worldwide Maternal Deaths,* 1988



**Numbers do not add to 100% because of rounding*
***Includes Australia, Canada, Europe, former USSR, Japan, New Zealand, and USA*

CHART 9C **SOUTHEAST ASIA**

Maternal Care

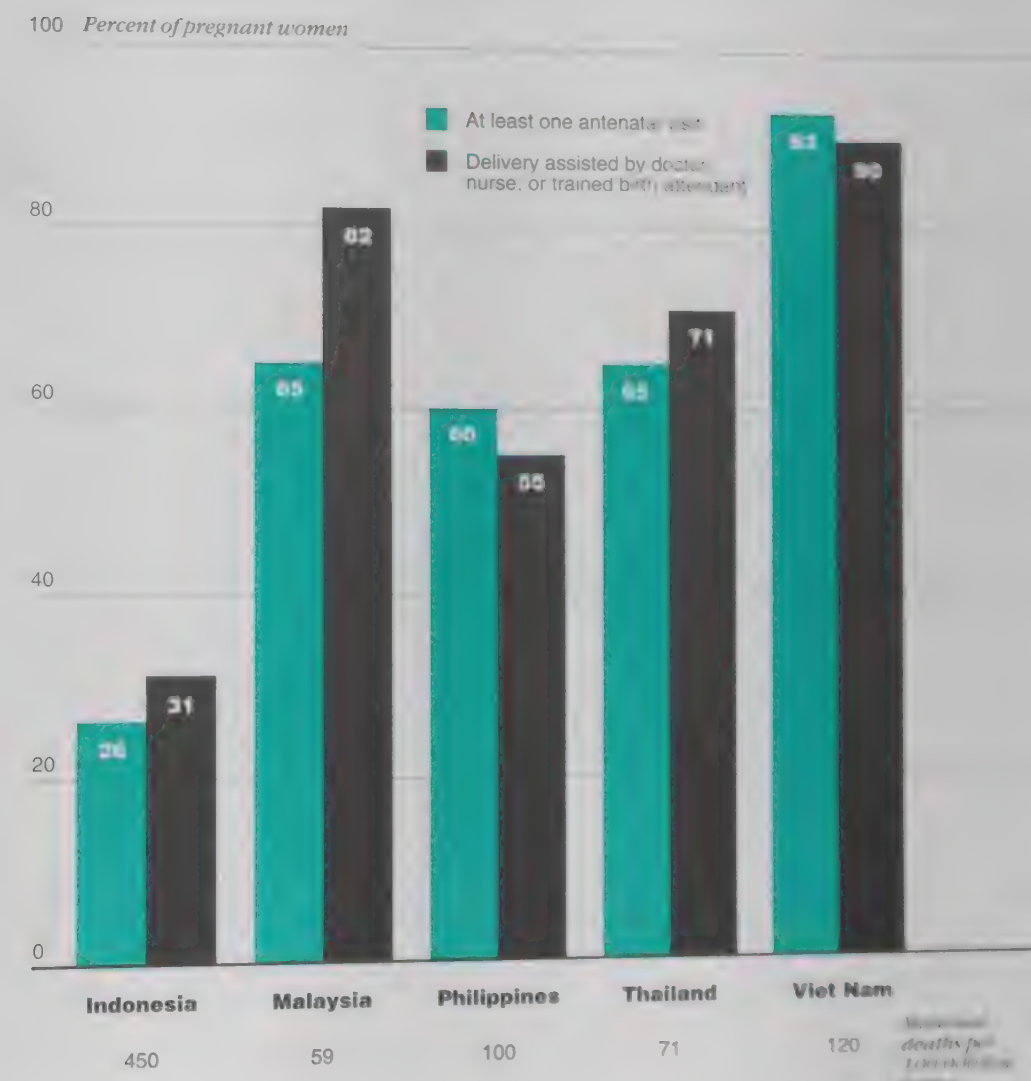
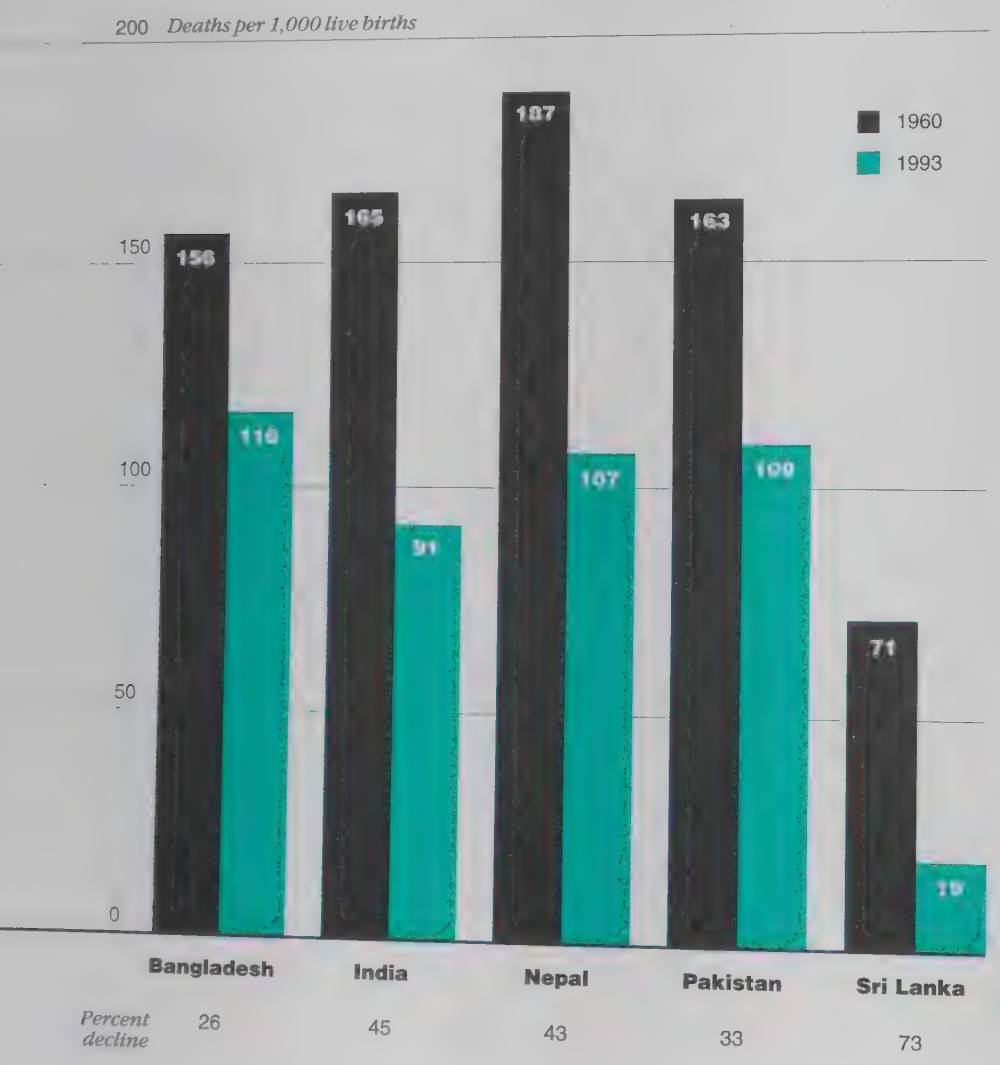


CHART 10A SOUTH ASIA

Decline in Infant Mortality



X. Infant Mortality

Charts 10A and 10C show declines in infant mortality in ten South and Southeast Asian countries. Infant mortality is often used as an indicator of the quality of health care services in a country. Other factors, such as access to safe water, sanitation facilities, and sufficient, nutritious food also influence infant mortality rates.

- Over the past three decades, infant mortality declined in each of the Asian countries profiled in these charts. However, the extent of the decline was more dramatic in Southeast Asia than in South Asia.

- On average, infants in South Asia face a higher risk of death than babies in Southeast Asia, where infant mortality rates are lower by about half. Health services are generally more sophisticated and wide reaching in more developed Southeast Asia.

Birthspacing and Infant Mortality

The relationship between birthspacing and infant survival is universal: in high and low mortality countries, spacing births by at least two years can reduce infant mortality rates *(see Chart 10B)*.

In Pakistan, for example, a baby born less than two years after a sibling faces twice the risk of dying than one born after a two-to-three year period. And when Pakistani women space births at intervals of four or more years, infant mortality drops by nearly 80 percent. Even in Thailand, with its relatively low infant mortality rates, the same relationship holds.

SEAN SPRAGUE/PANOS PICTURES

In high and low mortality countries, spacing births by at least two years can reduce infant mortality.

Family planning, therefore, plays a significant role in reducing infant mortality because it helps couples achieve healthy birthspacing. Couples may be more likely to use contraception if they are aware of these important health benefits.

CHART 10B

Infant Mortality Rate by Birth Interval

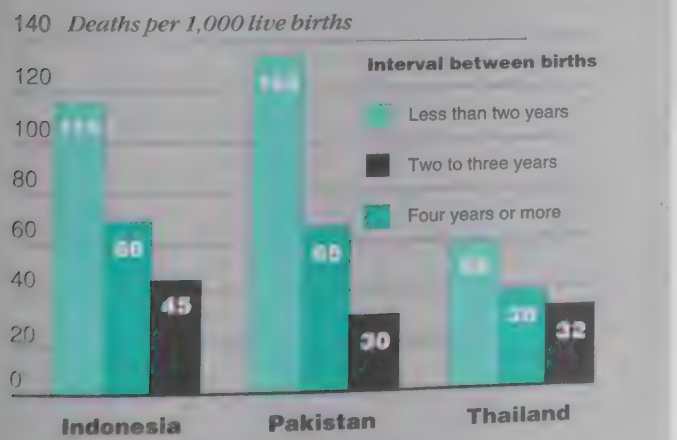


CHART 10C SOUTHEAST ASIA

Decline in Infant Mortality

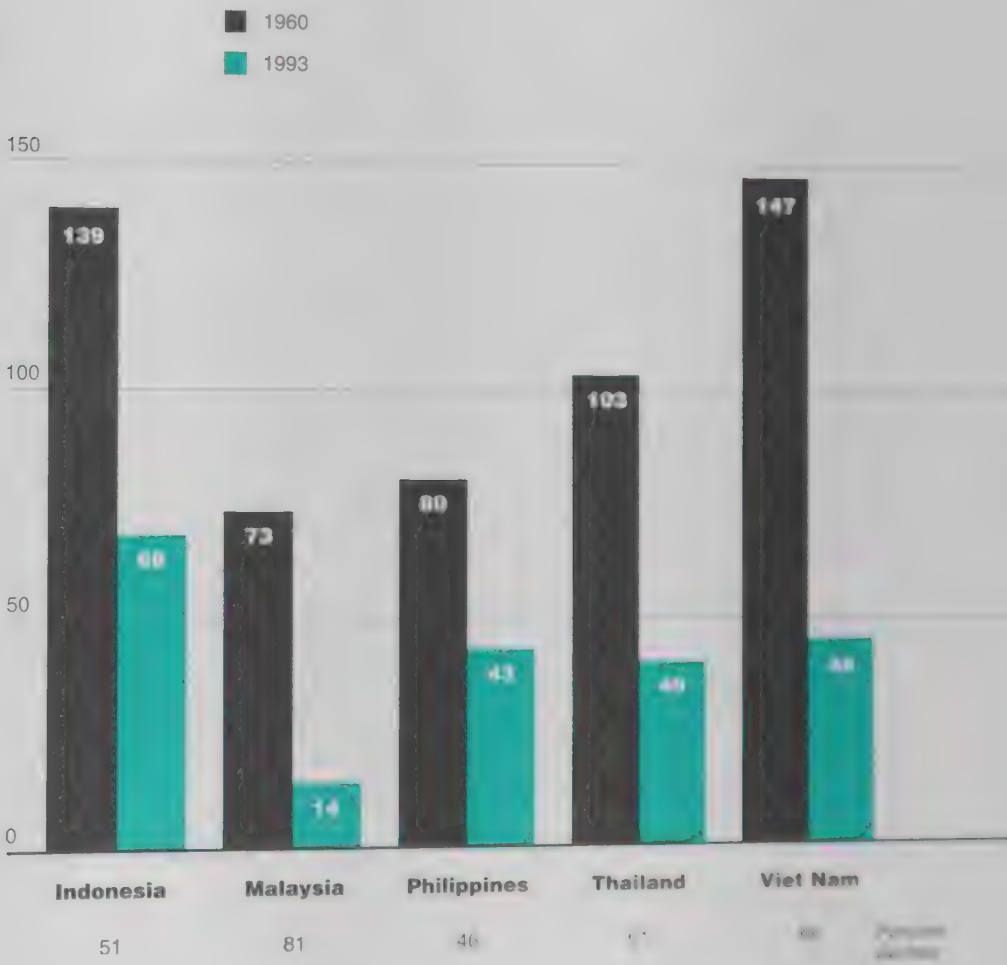
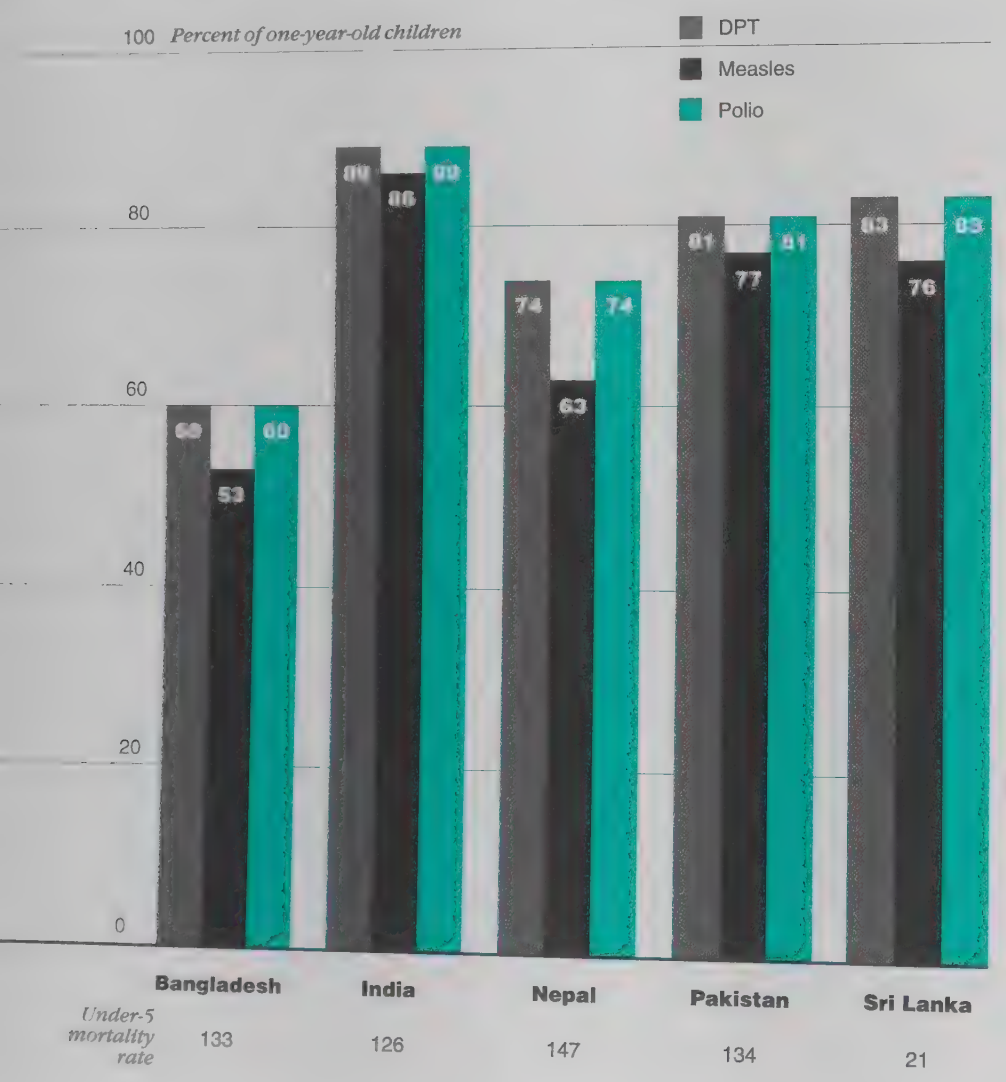


CHART 11A SOUTH ASIA

Immunization by Age One, 1990–1991



XI. Child Immunization

In many countries, children die of diseases that are preventable. Charts 11A and 11B show the proportions of Asian children that by age one, have been fully immunized against five potentially fatal diseases: measles; diphtheria, pertussis, and tetanus (DPT);* and polio. The charts also show mortality rates of children under five years of age for each of the countries.**

In order to ensure proper protection against DPT and polio, children must have full immunization courses consisting of three shots each at the proper times. Many children receive only one or two of the shots required for complete DPT or polio protection.

- With some exceptions, a higher proportion of children in Southeast Asia are protected from DPT, measles, and polio than in South Asia. This corresponds with the higher under-five mortality rates in South Asia.

- Despite fairly high levels of immunization, some countries still have high child mortality rates, indicating the need for broad-based efforts to improve child survival. In India, for example, levels of immunization are comparable to those found in Southeast Asia, yet child mortality is much higher.

* *One series of vaccination has been developed to provide immunization against all three diseases.*

** *The under-five mortality rate is the number of deaths to children less than age 5 per 1,000 live births.*

Except in Viet Nam, a smaller proportion of children have received immunizations for measles, which can be fatal, than for the other diseases. Yet, measles is still prevalent in many parts of the world, and periodic outbreaks have been reported even in developed countries.

Immunization programs have the potential to improve child survival significantly. In areas where there is an existing health infrastructure, program managers can more easily incorporate immunizations into the range of services.

MAURICE HARVEY/PANOS PICTURES

Immunization programs have the potential to improve child survival.

CHART 11B SOUTHEAST ASIA

Immunization by Age One, 1990–1991

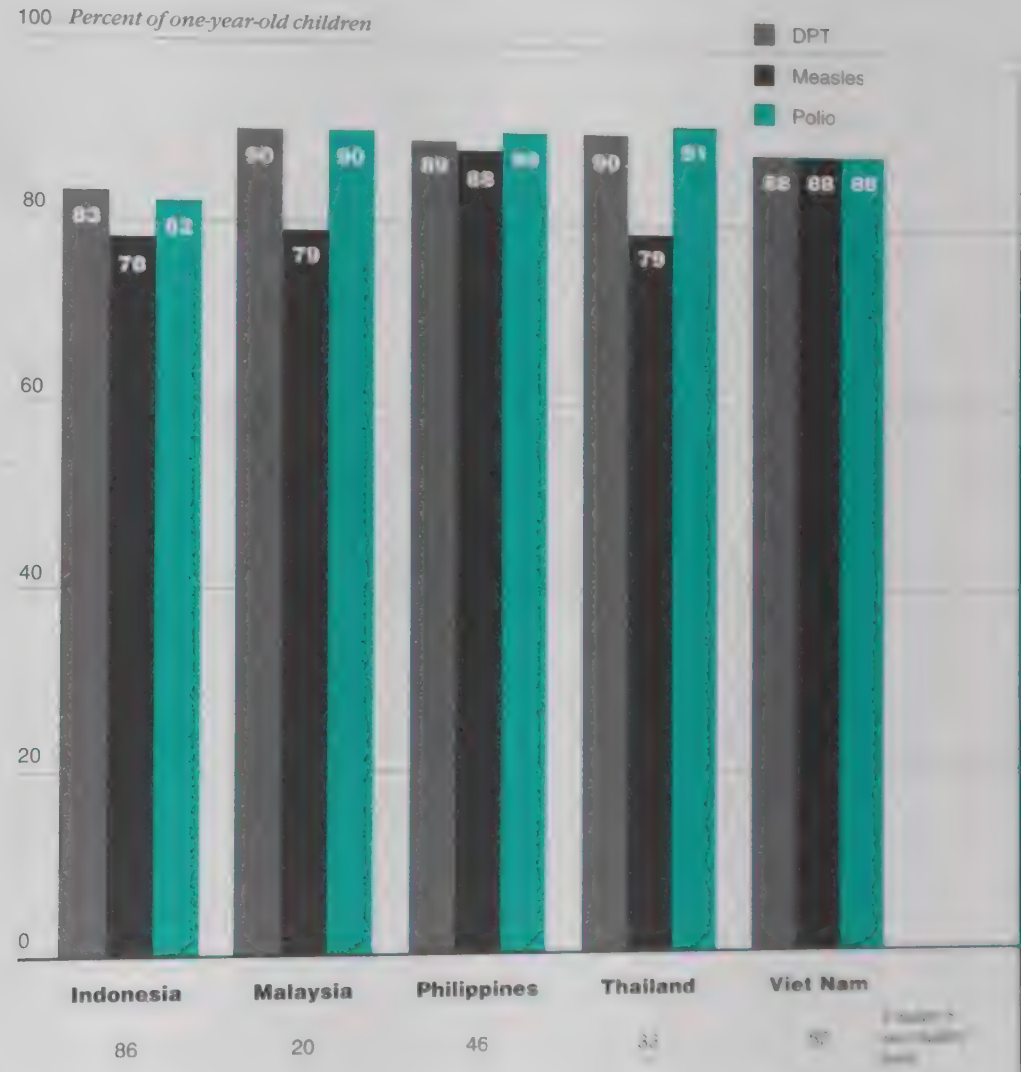
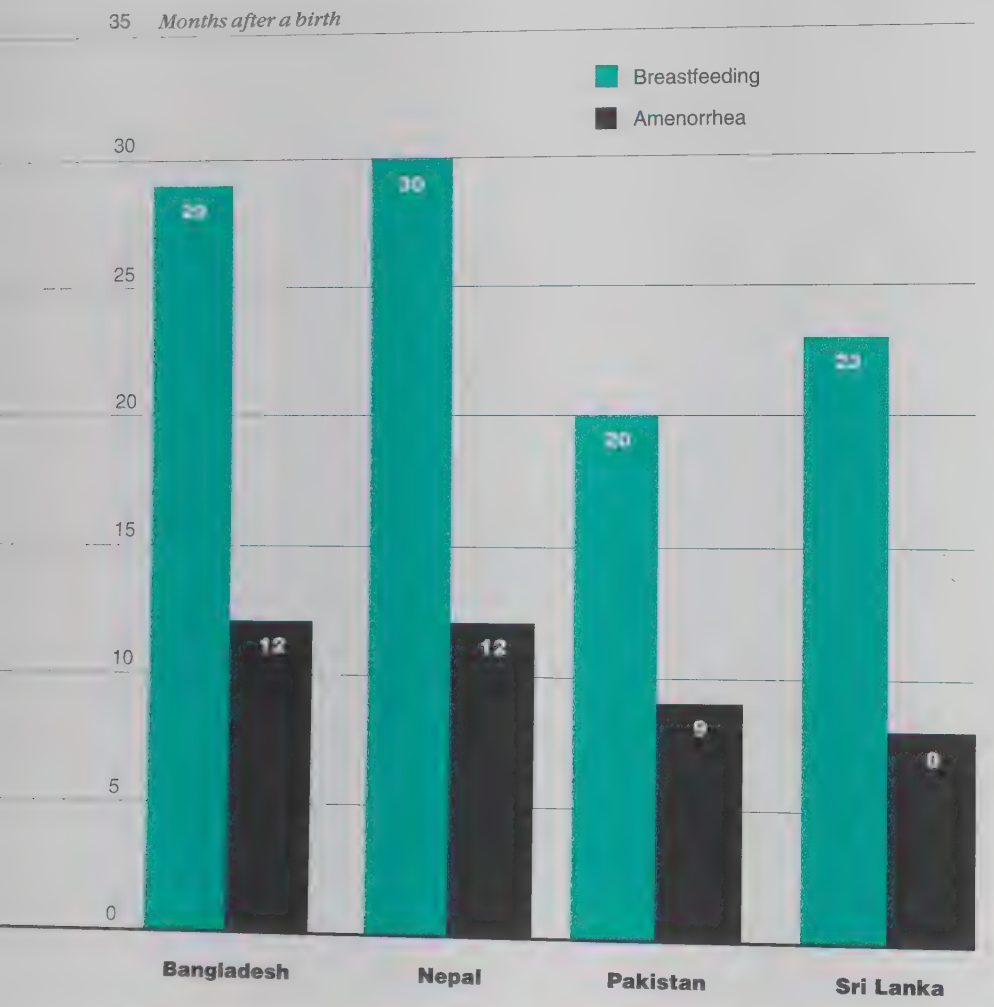


CHART 12A SOUTH ASIA

Average Duration of Breastfeeding and Amenorrhea*



*Mean duration except in Nepal, where data are median duration

XII. Traditional Fertility and Health Practices

Breastfeeding plays a vital role in keeping infants healthy by providing adequate nutrition and a natural immunity to various diseases. In addition, when women are fully breastfeeding their newborns – in other words, not providing any supplemental foods – they are less apt to become pregnant because breastfeeding inhibits ovulation. The length of this infecund period, called postpartum amenorrhea, can vary depending on a woman's health and the frequency and extent of her breastfeeding.

Charts 12A and 12C show the average duration of breastfeeding for nine South and Southeast Asian countries, and where data are available, the length of postpartum amenorrhea.

- Asian women generally breastfeed well past the six months after childbirth recommended by the World Health Organization.
- On average, the duration of breastfeeding in Southeast Asia is shorter than in South Asia. During the 1970s, the length of breastfeeding declined in Southeast Asia among urban resident and more educated or wealthier women.
- The period of postpartum amenorrhea, which is a rough indicator of the contraceptive effects of breastfeeding, is much shorter than the duration of breastfeeding.

The beneficial effects of breastfeeding are universal. In both developed and developing countries, programs that advocate breastfeeding in lieu of infant formulas can enhance child survival. Furthermore, on a household level, breastfeeding is more economical and often safer than purchasing infant formula, which can be expensive and potentially dangerous if prepared with unclean water.

Postpartum Abstinence

Chart 12B shows the average length that women abstain from sexual relations after childbirth in several Asian countries. Throughout Asia, many couples practice postpartum abstinence – ranging from four to seven months in the countries shown here. During this time, women clearly will not become pregnant, and thus, postpartum abstinence is another traditional practice that helps women achieve healthy birthspacing.

CHART 12B

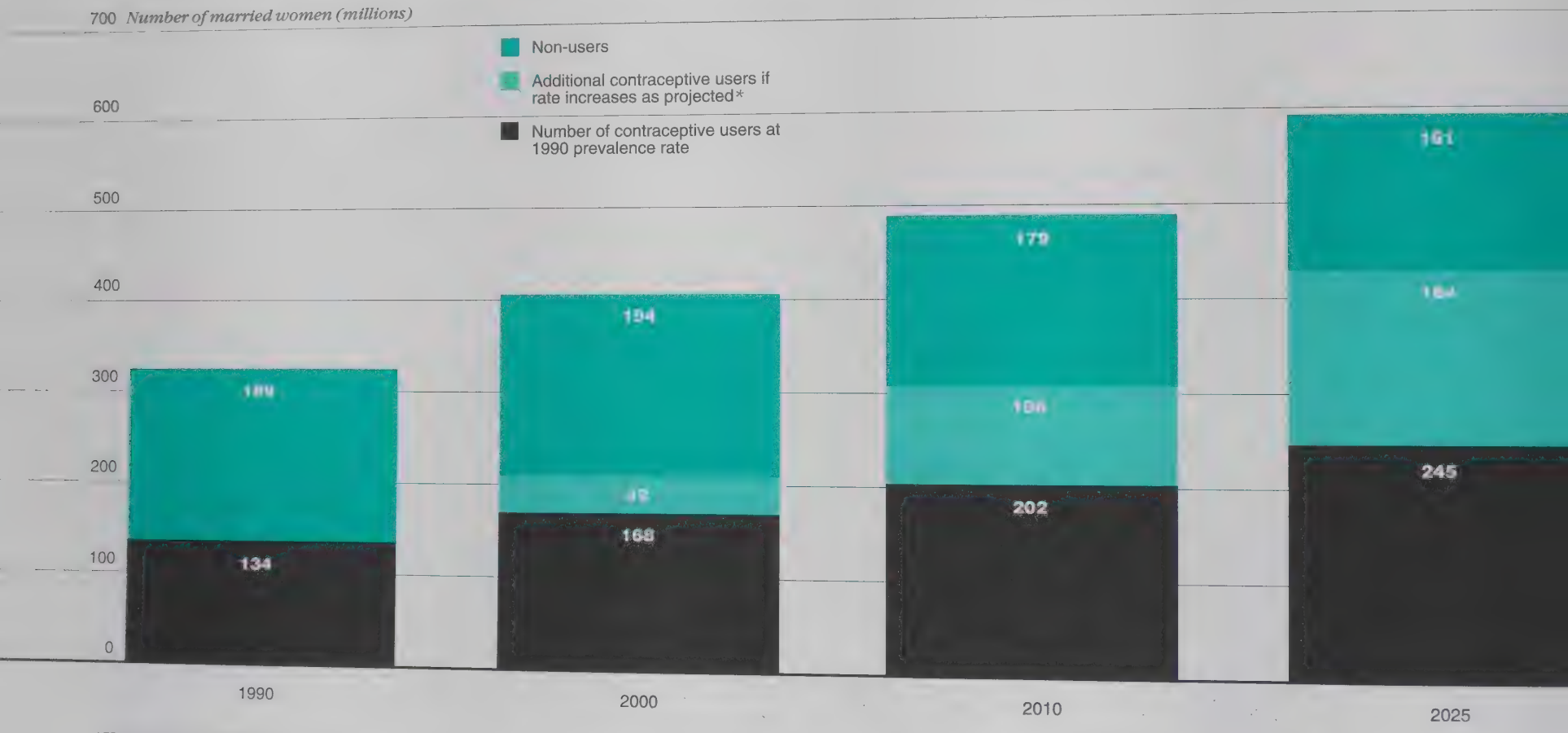
Average Duration of Post-Partum Abstinence

CHART 12C SOUTHEAST ASIA

Average Duration of Breastfeeding and Amenorrhea*

*Mean duration except in Malaysia, where data are median duration

Projected Growth in Family Planning Users



*United Nations medium variant

XIII. The Future

Overall, South and Southeast Asian countries have made great progress in reducing fertility and improving the health status of their populations. However, many challenges lie ahead for countries within the two regions.

As Chart 13 shows, even if countries are able to maintain current levels of contraceptive use, the number of married women that family planning programs will have to serve increases dramatically – from 134 million in 1990 to 245 million by the year 2025. Thus, even sustaining past success will be a challenge.

Furthermore, if countries expect to increase the prevalence of family planning practice, as the United Nations projects they will, then programs must prepare to provide services to more than three times as many couples in 2025 as were served in 1990.

Countries face difficulties particular to their situations; thus overcoming some of these difficulties may be more strenuous for some countries than for others. Nevertheless, meeting the following challenges could enhance the quality of life among Asian populations:

- **Increase awareness of the benefits of family planning.** Where both family planning knowledge and contraceptive use are low, as in Pakistan, efforts to raise general awareness of family planning options and the advantages of birthspacing could result in beneficial health and socioeconomic changes.

- **Enhance the quality of services.** In countries with low contraceptive prevalence, such as Nepal and the Philippines, improving family planning services and information and ensuring their accessibility have the potential to increase family planning use. Even in countries with higher prevalence rates, like Thailand and Indonesia, there are women who have an unmet need for family planning.

- **Offer a wide array of family planning methods.** To meet the needs of future generations, family planning programs should provide a wide array of contraceptive choices, including temporary and permanent methods. For example, improving access to temporary methods in countries where the majority of contraceptive users rely on sterilization would allow couples to plan the timing of their births better.

- **Broaden the range of reproductive health services.** Asian countries, and especially those in South Asia, should improve reproductive health services to provide better care to women throughout their lives, including during pregnancy and at the time of delivery. A good reproductive health program will include family planning so that high risk women can avoid illness or death.

- **Strengthen child survival programs.** In many of the countries profiled in this chartbook, infant and child mortality rates are still high. Increasing awareness of the benefits of birthspacing and breastfeeding and improved access to preventive services such as immunization and well baby care can improve child survival.

1993 Population Data

	Population Estimate mid-1993 (millions)	Birth Rate (per 1,000 pop.)	Death Rate (per 1,000 pop.)	Natural Increase (annual, %)	Population "Doubling Time" in Years (at current rate)	Population Projected to 2010 (millions)	Population Projected to 2025 (millions)	Infant Mortality Rate[a]	Total Fertility Rate[b]	%Population Under Age 15/65+	Life Expectancy at Birth Total/Male/Female (years)	Urban Population (%)	Data Availability Code[c]	%Married Women Using Contraception (Total/Modern)	Government View of Fertility Level (H=too high, S=satisfactory, L=too low)	Per capita GNP, 1991 (US$)
SOUTH ASIA	**1,253**	**34**	**11**	**2.3**	**31**	**1,717**	**2,144**	**96**	**4.4**	**38/ 4**	**58/58/58**	**26**		**41/35**		**430**
Afghanistan	17.4	49	22	2.8	25	34.6	48.8	168	6.9	46/ 4	42/42/43	18	D	-/-	H	-
Bangladesh	113.9	37	13	2.4	29	164.8	211.2	116	4.9	44/ 3	53/54/53	14	B	40/31	H	220
Bhutan	0.8	40	17	2.3	30	1.1	1.5	130	5.5	39/ 4	49/50/48	13	D	-/-	S	180
India	897.4	31	10	2.1	34	1,166.2	1,379.6	91	3.9	36/ 4	59/58/59	26	B	45/40	H	330
Iran	62.8	45	10	3.5	20	106.8	161.9	76	6.6	47/ 3	62/62/62	54	C	-/22	H	2,320
Maldives	0.2	41	6	3.4	20	0.4	0.6	34	5.8	47/ 3	61/62/59	28	B	-/-	S	460
Nepal	20.4	41	16	2.5	28	30.5	41.0	107	5.6	42/ 3	54/55/53	8	B	25/24	H	180
Pakistan	122.4	44	13	3.1	23	190.7	275.1	109	6.7	44/ 4	56/56/57	28	B	12/ 9	H	400
Sri Lanka	17.8	20	6	1.4	49	21.4	24.0	19	2.3	35/ 4	71/68/74	22	A	62/40	H	500
SOUTHEAST ASIA	**460**	**28**	**8**	**1.9**	**36**	**593**	**696**	**57**	**3.4**	**36/ 4**	**62/60/64**	**29**		**51/44**		**980**
Brunei	0.3	29	3	2.6	27	0.4	0.5	9	3.5	36/ 3	71/69/72	59	A	-/-	S	-
Cambodia	9.0	41	15	2.5	27	13.0	16.7	123	4.6	35/ 3	50/48/51	13	D	-/-	L	200
Indonesia	187.6	26	9	1.7	42	238.8	278.2	68	3.0	37/ 4	59/58/61	31	B	50/47	H	610
Laos	4.6	45	16	2.9	24	7.2	9.8	110	6.3	45/ 4	50/49/52	19	C	-/-	S	230
Malaysia	18.4	28	5	2.3	30	26.0	33.5	14	3.6	37/ 4	71/69/73	51	B	56/37	H	2,490
Myanmar (Burma)	43.5	30	11	1.9	36	57.7	69.9	72	3.9	37/ 4	58/56/60	24	C	-/-	S	-
Philippines	64.6	32	7	2.5	28	85.5	100.8	43	4.1	39/ 4	64/63/66	43	B	36/22	H	740
Singapore	2.8	17	5	1.3	55	3.2	3.3	6	1.7	23/ 6	74/72/77	100	A	74/73	L	12,890
Thailand	57.2	21	7	1.4	49	69.2	76.4	40	2.4	29/ 5	68/66/71	19	B	66/64	H	1,580
Viet Nam	71.8	30	8	2.2	31	91.7	107.2	45	4.0	39/ 5	64/62/66	20	B	53/38	H	-

Source: Population Reference Bureau, *World Population Data Sheet, 1993.*

a *Infant deaths per 1,000 live births*

b *Average number of children born to a woman during her lifetime*

c *A = complete data . . . D = litte or no data*

Additional Sources

CHART 1: *World Population Prospects, The 1992 Revision,* United Nations: New York, 1993.

CHARTS 2A AND 2C: 1960 data from *World Population Prospects, The 1992 Revision,* United Nations: New York, 1993; 1993 data from *World Population Data Sheet, 1993,* Population Reference Bureau: Washington, DC, 1993.

CHARTS 3A AND 3B: *World Population Data Sheet, 1993,* Population Reference Bureau, Washington, DC, 1993.

CHARTS 9A AND 9C: Maternal care data from *Maternal Mortality: A Global Factbook,* World Health Organization: Geneva, Switzerland, 1991; except for the Pakistan data, which come from the survey listed on page 5. Maternal mortality rates from *State of the World's Children 1993,* UNICEF: New York, 1993.

CHART 9B: *Maternal Mortality Ratios and Rates: A Tabulation of Available Information,* World Health Organization: Geneva, Switzerland, 1991.

CHARTS 10A AND 10C: 1960 data from *World Population Prospects, The 1992 Revision,* United Nations: New York, 1993; 1993 data from *World Population Data Sheet, 1993,* Population Reference Bureau: Washington, DC, 1993.

CHARTS 11A AND 11B: *State of the World's Children 1993,* UNICEF: New York, 1993.

CHART 13: *Levels and Trends of Contraceptive Use, as assessed in 1988,* United Nations: New York, 1989.

PRB
International Programs
Population Reference Bureau
1875 Connecticut Avenue, NW, Suite 520
Washington, DC 20009 U.S.A.